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ABSTRACT

The many difficulties involved in diagnosing, classifying and treating alcoholics comprise the bulk of the report's content. The very specific social and medical needs of the alcoholic, coupled with personal, social and treatment agency barriers, are viewed as the major feasibility (for treatment outcome) factors. The report recommends six major treatment approaches: (1) acute detoxification; (2) chronic detoxification; (3) environmental manipulation; (4) supportive therapy; (5) internal change therapy; and (6) treatment for the counter-alcoholic. In the concluding chapter, a cooperative program concept for providing services to the alcoholic is preferred. A coordination of all needed services in an intensive comprehensive program is seen to be the only method from which successful rehabilitation can be expected. (TL)

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REHABILITATION OF THE ALCOHOLIC

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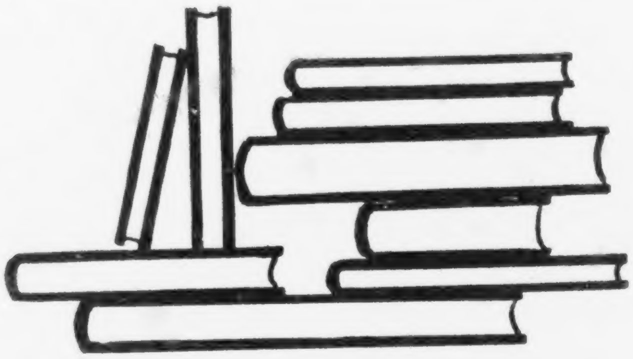

a training guide

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service
Rehabilitation Services Administration

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REHABILITATION
OF THE
ALCOHOLIC

A Report from the Study Group on Rehabilitation

of the

Alcoholic and Public Offender

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FOREWORD

Rehabilitation programs are rapidly developing many special approaches to serving selected target groups of disabled and disadvantaged persons. The intensity of many of these efforts has brought the service to the frontier of knowledge where ingenuity and innovation are requisite for further progress.

Probably no large group of persons have been less well served by society than those addicted to excessive use of alcohol. Techniques and effective approaches to rehabilitation services for them are just now being devised. The progress made has required bold experimentation and intensive study.

The Study Committee of the Institute on Rehabilitation Services has been diligent in seeking out and recording in this manual much of the best information available on rehabilitation of the alcoholic. The material presented here should certainly assist those State agencies who are engaged in substantial work with the alcoholic to enrich their existing programs. Those State programs that are seeking to devise means for serving the alcoholic will certainly find here many helpful suggestions. In-service training programs will surely be enriched by the availability of this material.

Joseph Hunt

Joseph Hunt
Commissioner

PREFACE

The Study Committee for 1968 on the Rehabilitation of the Alcoholic was charged with continuing the study which had begun with a survey in 1967. Results of the survey are included in Chapter I of this report.

The general purpose of the study was given by the Planning Committee as follows: "This group should make a thorough study of the problems and the effective practices in working with this group. They should develop an approach to gearing our program and preparing staff to serve the alcoholic."

Specific charges included: (1) develop a working definition of the alcoholic for rehabilitation purposes; (2) obtain information on the magnitude of the problem with its effects on the economic and social aspects of family and community; (3) survey State rehabilitation agency policies and practices in serving the alcoholic; (4) identify and suggest resources in communities for use by agencies and counselors in serving the alcoholic; (5) identify techniques, methods, and special skills which are particularly applicable to the rehabilitation of the alcoholic; (6) identify special problems such as attitudes, expectations, and techniques which might be used in motivating the rehabilitation staff to work with this disability group.

Approach to the Study

In considering the extensive nature of the charges the Group recognized the need for intensive study in the various aspects of the problem and the need for dividing into sub-committees for this purpose. The Group also felt the need for calling on certain resource people to assist with the work of the Group.

It was decided that sub-committees would have responsibility of certain phases of the study. For an example, one group was assigned the task of identifying and utilizing available community resources. Similar assignments were made for all the other aspects of the study. It was further determined that the Group would hold its meetings in different locations each time and ask resource people from that particular area as well as other specialists in the field to meet with the Group and assist with the work.

The subcommittees were asked to correspond with each other as needed, exchanging material and holding meetings if possible to accomplish their particular assignments. At succeeding meetings the material of each subcommittee was reviewed by the entire Group, amended as indicated, and adopted by the Group for use in the final report.

The Final Report

The Group felt that it should concentrate on making the main body of the report as brief as possible, concise, and to the point. In other words, it was felt that the charges should be fulfilled but that the report should be readable and useful. It was further determined that the appendix should be in greater detail and more all-inclusive of information and resource material that might be helpful in working with the alcoholic.

The Chairman is deeply grateful to the members of the Prime Study Group who devoted their interest, time, and effort to making the study and contributing to the final report: Mr. Max Arrell, Assistant Director, Texas rehabilitation agency; Dr. William Bean, RSA staff, Washington; Dr. Jack Blackley, Medical Director, N. C. Alcoholic Center; Mr. William Crunk, Associate Regional Commissioner, RSA, Charlottesville, Virginia; Dr. Vernelle Fox, Medical Director, Georgian Clinic; Mr. Robert Gibson, N. C. rehabilitation agency; Dr. Thomas L. Porter, Project Director, University of Georgia; Mr. Michael Spruell, Assistant Coordinator, University of Georgia; Mr. Robert Stevens, Counselor, Georgian Clinic; and Dr. Harold Viaille, Project Director, Oklahoma rehabilitation agency.

In addition to members of the Prime Study Group, the following met and worked with the committee and rendered valuable assistance: Mr. Glen Calmes, Assistant Regional

Representative, RSA, Atlanta; Mr. Roger Decker, Supervisor of Intake, Iowa rehabilitation agency; Mr. Ben Dixon, Project Supervisor, S. C. Alcoholic Center; Mr. B. F. Sims, District Supervisor, Alabama rehabilitation agency; and Dr. James H. Williams, Project Director, Florida Alcoholic Program.

James McClary
Columbia, South Carolina

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DESCRIPTION OF APPENDICES

Appendix A Emory University Project for the Expansion of Vocational Rehabilitation Services to the Chronic Drunk Court Offender Alcoholic

Recent court rulings and the increasing acceptance of the disease concept of alcoholism have brought the problems of the chronic alcoholic court offender into sharper focus. This appendix is a copy of the original proposal and a revision of the intake and screening procedures in use at the Emory University Alcohol Project in Atlanta, Georgia. The appendix should be of special interest to persons and agencies interested in providing vocational rehabilitation services to this largely neglected segment of the alcoholic population.

Appendix B A Sample Proposal and Agreement

State vocational rehabilitation agencies have realized substantial success in recent years by working cooperatively in the rehabilitation of seriously impaired clients. This appendix could serve as a guide for those persons and agencies wishing to combine and coordinate their resources and work cooperatively toward providing a more effective rehabilitation program for the alcoholic. The Sample Proposal and Agreement reproduced is that between the North Carolina vocational rehabilitation agency and the Alcoholic Rehabilitation Center in Butner, North Carolina.

Appendix C Review of Literature and Selected References

The purpose of this appendix is to provide the reader a brief overview of the major findings and to provide references to related literature and research on alcoholism pertinent to the following categories: (1) personality factors, (2) physiological factors, (3) socio-cultural factors, and (4) effects of treatment. This appendix should be helpful to those desiring further information in these significant areas.

Appendices
D & E

Research and Demonstration Projects on Alcoholism Funded by Social and Rehabilitation Service, 1967 & Expansion Grants or Innovation Projects Funded by Rehabilitation Services Administration, 1968

Research, demonstration, and innovation projects have proven to be effective in devising new techniques and methods for working with the alcoholic disability group. Appendix D is a list of Research and Demonstration Projects funded by SRS in 1967. Appendix E is a list of the Expansion Grants or Innovation Projects sponsored by RSA in 1968. These appendices should be helpful to those doing research and to those people who wish to be acquainted with the current innovations in the rehabilitation of persons with alcoholism.

Appendix F

Training Courses 1968

The complexity of the problem of alcoholism requires an unique orientation in order for rehabilitation personnel to work effectively with this disability group. Special workshops, training courses, and orientation courses are available to fill this need. This appendix provides a list of these programs which can be effectively utilized by persons and agencies preparing personnel to work with this disability.

Appendix G

Films for Loan

Films on alcoholism can be used as an effective tool in educating the alcoholic as to the nature of his disease. They can also be used effectively with lay groups in facilitating understanding of the problem. This appendix provides a list of films on the various aspects of alcoholism which are available for loan and a supplementary list of films on rehabilitation of the alcoholic sponsored by RSA and available for purchase only.

Appendix H

Alcoholism:
Treacherous but Treatable

This appendix contains an outline of information designed primarily for physicians inexperienced in the treatment of alcoholism. Those using this report should make this information available to physicians whom they feel could profit from it.

Appendix I

Roster

This appendix provides a list of the names and addresses of the full Study Committee. These committee members were charged with the responsibility of assisting in the compilation of the material presented in this study.

SUMMARY OF STUDY

Rehabilitation of the Alcoholic

Chapter I Introduction

Rehabilitation of the alcoholic is one of the most difficult areas facing the rehabilitation counselor today. This difficulty should not, however, hide the fact that this is one of the most worthwhile areas in which the counselor can become involved and one in which he has an unique and effective service to offer. Many alcoholics who have refrained from drinking have been found to be extremely creative and productive citizens.

John W. Gardner, former Secretary of Health, Education, and Welfare, very succinctly outlined the nature of the problem in the following statement:

> No other national health problem has been so seriously neglected as alcoholism. Many doctors decline to accept alcoholics as patients. Most hospitals refuse to admit alcoholics. Available methods of treatment have not been widely applied. Research on alcoholism and excessive drinking has received virtually no significant support.
>
> The atmosphere of moral disapproval surrounding the entire subject, and the deplorable custom of treating alcoholics as sinners or criminals have obscured the nature of the problem.
>
> But now we recognize that alcoholism is an illness - no more moral or immoral than tuberculosis or pneumonia or schizophrenia - and that our ways of dealing with that illness have been shockingly inadequate.

Chapter II Definition and Classification of the Alcoholic

The diagnosis of "alcoholism" does not have generic meaning. In fact, it cannot since there is as much variance within a population of alcoholics as the population in general. The excessive consumption of alcohol is frequently the only common denominator. Also, there are many people who have a drinking problem that are not alcoholics.

An adequate operational classification system of alcoholics would be of considerable benefit to lay and professional people in accelerating the process of case finding, diagnosis, treatment, arriving at a prognosis, and eventually the rehabilitation of the alcoholic.

Any classification system proposed at this point can only give broad concepts of the approximate treatment, attitude, and expectations of outcome. Since the etiology and epidemiology of this disability group is not yet known, it is imperative that the rehabilitation counselor evaluate each client in terms of the assets and liabilities the person brings with him, his potential assets, and the sources of help that can be mobilized in each particular situation.

Chapter III The Needs of the Alcoholic

The questions are often appropriately asked, "What is the difference in the needs of these clients and the requirements for adequate services for the alcoholic and other disturbed patients?" "Why can't they be treated in the same program as other adult psychiatric patients?" There are many similarities between these groups of patients, but alcoholics have very specific needs that necessitate special approaches if treatment is to be effective. The following is an outline of these needs.

I. What is unique about the alcoholic?

   A. Drinking is his solution to his disability.
   B. Medical complications usually present.
   C. Uses drinking behavior to hide primary disability.
   D. Has ambivalence about commitment to life or death.

II. What are the special services needed by the alcoholic?

   A. Continuously available peer or reference group.
   B. Medical management of acute and chronic disabilities.
   C. Awareness of the fact that he uses drinking behavior to hide primary disability.
   D. Help in facing up to his lack of commitment to life or death.

III. What are the barriers to providing these services?

   A. Society's ambivalence about drinking.
   B. Lack of know-how in using existing treatment aids.
   C. Previous poor experiences associated with alcoholics and lack of awareness that drinking behavior is being used to hide primary disability.
   D. Pressure for production on counselors and other helpers.

Chapter IV Feasibility Considerations

Feasibility considerations are of special importance when considering the alcoholic disability group. The requirements for acceptance for services can usually be interpreted broadly enough to provide services to the alcoholic or so stringently as to exclude him. The ultimate decision is usually left to the counselor's discretion and his interpretation of administrative policy as explicitly or implicitly stated.

Arriving at an adequate definition of alcoholism is a complex problem. For the purposes of this report, the Study Group has adopted the definition which has been approved by the American Medical Association. It is:

> Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression; and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational, and/or social adjustment as a direct consequence of persistent and excessive use.

According to the National Council on Alcoholism, alcoholism is the fourth major public health problem in the country. The problem is more severe in urban areas than in rural ones. Only a small portion of the alcoholic population is of the skid-row type. According to statistics compiled by The Center of Alcohol Studies at Rutgers University, we have an estimated 4.50 million alcoholics in the United States. Of these, approximately, 3.75 million are males.

In order to begin to meet the needs of the alcoholic disability group, State rehabilitation agencies must use all of the resources and creativity at their disposal. In the spring of 1967, a questionnaire was directed to all general rehabilitation agencies regarding their work with alcoholics in the fiscal year 1965-66. Of all the agencies contacted, 60% responded to the questionnaire. It is obvious in terms of the 4.5 million alcoholics in the United States that we are barely scratching the surface in terms of services to the alcoholic. Only 33% of those alcoholics referred for services were accepted for services (.00042% of the total number of alcoholics).

The above statistics and a subsequent postcard survey conducted in the spring of 1968 indicate the general lack of emphasis that rehabilitation agencies as a whole devote to the rehabilitation of the alcoholic.

Before accepting any applicant for services, the rehabilitation counselor is required to establish that:

1. The individual has a physical or mental disability.
2. A substantial handicap to employment exists.
3. There is a reasonable expectation that rehabilitation services may render the individual fit to engage in a gainful occupation.

Feasibility of an applicant should depend in part on the degree to which treatment and rehabilitation resources are available. These resources include buildings, programs, and adequate equipment, but most important, competent people. The alcoholic has a problem with people, and people have a problem with him. People are involved in his illness; therefore, they must be involved in his rehabilitation. There is no benefit to him in being declared feasible for vocational rehabilitation services if those services do not include the opportunity to become involved with persons who can assist in the reconstruction of his self-concept.

Chapter V Treatment Modalities

Acute detoxification which is needed by almost all alcoholics consists of treatment for the acute withdrawal symptoms: (a) a good physical examination and the appropriate treatment of anything that is found and (b) appropriate laboratory work. On the basis of the general physical, a good internist would be expected to provide any additional work needed. The above is the minimum screening that these clients need if adequate program is to be designed for them.

Subsequent to the above minimum screening, the following six major treatment approaches may be utilized:

1. Acute detoxification
2. Chronic detoxification
3. Environmental manipulation
4. Supportive therapy
5. Internal change therapy
6. Treatment for the counter-alcoholic

These approaches may be used individually or in combination to achieve the desired goal. All of the above treatment attitudes are by necessity generalizations which can only serve as broad suggestions for the rehabilitation counselor.

In spite of the lack of clear guidelines and proven treatment approaches in this complex area, the rehabilitation counselor is in a better position than almost any other helping professional to function as a coordinator to insure the kinds of services and continuity of care that is essential for this difficult group of clients. He has the prerogative of crossing disciplinary lines, requesting specific services, and in turn utilizing and integrating these services to the ultimate benefit of the client.

Chapter VI Identification and Utilization of Available Resources

Alcoholic rehabilitation programs require a coordinated treatment approach using the knowledge and skill of a wide variety of professional and lay resources. The resources available to meet the needs of clients with alcoholism will vary greatly between and within the states. In addition to consideration of the resources available in the community and those which could be developed, the rehabilitation counselor should also think in terms of the client's going to another community for services not available locally.

A list of public agencies and facilities usually available as resources for development and use by the rehabilitation counselor working with alcoholics is provided in this chapter. Since the function of these agencies and groups vary somewhat from one locality to another, the counselor will need to contact the agency representatives in his area and determine the services which they provide.

Chapter VII Implementation of Programs for Rehabilitation of the Alcoholic

During the last decade, a number of RSA supported projects have demonstrated the value of rehabilitation concepts and services in the treatment and rehabilitation of alcoholics. These projects have been conducted in various parts of the nation and with a variety of groups. They have provided conclusive evidence that the costs for rehabilitating alcoholics were considerably cheaper and the long-range results more rewarding than the "revolving door" method of continued arrests and incarceration of the alcoholic.

A recent survey made of State program efforts directed toward rehabilitating alcoholics indicated the following program patterns:

1. The alcoholic is accepted as a referral from the general population and is evaluated for rehabilitation services the same as other disability groups.
2. Most alcoholics are received as referrals from State mental hospitals after treatment has been provided, and the referral to rehabilitation counselors is on the same basis as any other referral in the mentally ill population served by the hospital.
3. Where Public Health or Mental Hygiene Clinics have established special treatment units for alcoholics, rehabilitation staffs have been assigned to serve referrals from the clinic.
4. Specially trained staffs have been employed to coordinate rehabilitation services for alcoholics and provide statewide follow-up on cases that are served through special alcoholic treatment centers. State agencies should develop a pre-service and in-service training program for all staff members working with the alcoholic and his

rehabilitation. There are many formal training programs throughout the country available at little or no cost.

These program patterns have provided services to increasing numbers of alcoholics and given us valuable experience in regard to the unique needs of this particular disability group. However, they have not proven as effective either quantitatively or qualitatively as desired.

Generally, services rendered independent of each other have not achieved the desired end in the treatment and rehabilitation of the alcoholic. A coordination of all needed services in an intensified comprehensive program for the alcoholic appears to be the only method from which successful rehabilitation can be expected.

The cooperative program concept for providing services to the alcoholic is simply a formalization of the commitments of two or more agencies to organize, improve, expand, and focus in the most meaningful way their respective services on the needs of the alcoholic. These needs encompass a broad spectrum of living, intellectual and cultural development, personal adjustment, personal and social counseling, job training, and job placement. It may include such additional services as family case work, special health programs, particularly health maintenance, special recreational programs including use of leisure time and the like.

The Federal government is no longer motivated by a social philosophy that merely forbids various practices or deals charitably with the unfortunate. It is motivated to reallocate resources through political actions which produce social justice, adequate education, housing, rehabilitation, and medical care. The spirit of the times demands that more attention be focused on the needs of the disadvantaged in our society. The needs of the alcoholic are of special importance. This is the era for concerted service programs, program decentralization, new approaches to planning, staff deployment, and cooperative funding.

Chapter I

INTRODUCTION

The purpose of this chapter is to provide information regarding the scope of the problem and to discuss the role of rehabilitation agencies in assisting the alcoholic to become an independent productive member of our society. John W. Gardner, former Secretary of Health, Education, and Welfare, very succinctly outlined the nature of the problem in the following statement:

> No other national health problem has been so seriously neglected as alcoholism. Many doctors decline to accept alcoholics as patients. Most hospitals refuse to admit alcoholics. Available methods of treatment have not been widely applied. Research on alcoholism and excessive drinking has received virtually no significant support.
>
> The atmosphere of moral disapproval surrounding the entire subject, and the deplorable custom of treating alcoholics as sinners or criminals have obscured the nature of the problem.
>
> But now we recognize that alcoholism is an illness - no more moral or immoral than tuberculosis or pneumonia or schizophrenia - and that our ways of dealing with the illness have been shockingly inadequate.

The study committee began their work with the basic assumption that alcoholism is a legitimate and remediable disability, thus rehabilitation agencies and counselors should be as concerned with the alcoholic as any other population of rehabilitation clients.

Arriving at a definition of the alcoholic proved to be a complex problem. In fact, one section of this report (Chapter II) is devoted to the various definitions and classification schemes which have been developed. However, for the purpose of this report we adopted the definition which has been approved by the American Medical Association. It is:

> Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression; and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational, and/or social adjustment as a direct consequence of persistent and excessive use.

The data included in the following section of this chapter is related to the scope of the problem. It clearly illustrates that in order for rehabilitation programs to fulfill their obligation to society, i.e., provide opportunities for all impaired individuals to develop their maximum potentialities, there must be a radical increase in creative efforts.

MAGNITUDE OF THE PROBLEM

The Number of Drinkers

The exact number of Americans who use alcoholic beverages is not known. Estimates suggest that the percentage has been increasing steadily for at least a century. A 1965 nationwide survey (Cisin, 1966) by the Social Research Group of George Washington University, which was based on a weighted sample of 2,746 subjects, indicated that 68% of all American adults - 77% of the men and 60% of the women - drink at least occasionally. And, while the proportion of men drinkers in the adult population has remained about constant in the past 20 years, the proportion of women drinkers has risen.

Out of all adults, the survey classed 56% as infrequent to moderate drinkers and 12% as heavy drinkers. The latter are not necessarily alcoholics, but they do include the problem drinker. They are more apt to be men than women (at a ratio of four to one) and - compared to abstainers and moderate drinkers - are usually younger and wealthier, entertain more, go to church less, and form closer friendships with fellow workers than with neighbors.

A 1963 survey found that the proportion of those who drink at all was highest in the Middle Atlantic and New England states and lowest among those over the age of 60, highest among Jews and Catholics and lowest among Baptists. Drinking was reported by 79% of those who were single, 72% of those who were married, 69% of those who were divorced, and 51% of those who were widowed. For the widows and widowers, the low percentages may have more a reflection of age than of marital status (Mulford, 1964).

Regarding the relationship of drinking and alcoholism, Keller (1958) says:

> Although drinking is not the same thing as alcoholism and not even the cause of alcoholism, drinking patterns and practices have their role in the problem. Aside from the fact that without drinking there could be no alcoholism, it must be borne in mind that the numbers who drink, as well as what, how much, and in what context they drink, can all decisively influence both the rate of alcoholism and its clinical manifestation...The changes which have occurred in American drinking customs in the past century have had their repercussions in the incidence of alcoholism, in the picture of the disorder as it presents itself to medical and other observers, and in the frequency and variety of its concomitant diseases. These conditions are still undergoing evolutionary changes (p. 8).

The Number of Alcoholics

According to the National Council on Alcoholism, alcoholism is currently considered the fourth major public health problem in the country and results in a billion dollar loss to industry each year. The estimated rate of alcoholism varies considerably from State to State, and city to city. However, it is evident that urban areas have a higher rate than rural ones. Only a small portion of the alcoholic population is to be found on skid row, perhaps less than 10%. The Center of Alcohol Studies at Rutgers University periodically publishes statistics on alcohol consumption and alcoholism. According to their most recent figures there are an estimated 4.50 million alcoholics in the United States. Of these, approximately, 3.75 million are males (Keller, 1958).

Concomitant Problems

Alcoholics are found in every level of society, and it has been estimated that more than 1,650,000 are currently employed in business and industry. This means that approximately 3% of the working force is affected by drinking to the point that their employer suffers in one way or another.

It is obvious that others suffer from the alcoholic's situation besides the alcoholic himself and his employer. It has been estimated that every alcoholic directly affects four or five other people. These may include his family, friends, neighbors, business associates, employers, and others. Therefore, if we want to look at the total number of persons affected by alcoholism in the United States, we would have to expand considerably the 4.50 million figure quoted above. A study relating to this aspect of alcoholism was conducted by Bailey (1967) in which she compared psychophysiological impairment in wives of alcoholics as related to their husband's drinking and sobriety. In general, the least psychophysiological impairment was found in currently married women with sober husbands, in the better educated wives, and in al-anon members. The evidence from this study suggests that although some wives need for their husbands to drink and their mental health will deteriorate if their husbands begin to recover, the majority have the capacity to improve in emotional health along with their husbands. The study also indicated that wives divorced or separated from their husbands were likely to be improved.

Large numbers of problem drinkers are in contact with various helping agencies. While these persons often are identified as problem drinkers, in many instances they receive little or no treatment for their drinking problems. The impact of problem drinkers on major American care-giving agencies is illustrated by the following statistics (PHS Pub. 1452). In 1964 there were slightly under 70,000 first admissions of male patients to the nearly 300 State mental hospitals in the United States. Over 15,000 of these patients, approximately 22%, were given a diagnosis of alcoholism at the time of their admission. Among women patients the proportion with alcoholic diagnoses was much lower - only 5.6%. Because problem drinkers generally have a short duration of stay in mental hospitals, the proportion of resident patients with alcoholic diagnoses is far lower - generally under 6% of all patients. Currently more patients are admitted to psychiatric wards in general hospitals than to State mental hospitals. The proportion of these patients who are alcoholic is virtually identical to the figure for mental hospitals.

Over 550,000 adult patients are seen each year in general psychiatric clinics. While the proportion of these patients diagnosed as alcoholics is relatively small (3% to 4%), the total number is between 15,000 and 25,000 (Bahn, 1963).

The impact of problem drinkers on the medical-surgical wards of general hospitals is illustrated by a study (Pearson, 1962) in which the extent of drinking problems among 100 consecutive male admissions to a general hospital was determined. No preselection was made in terms of the diagnosis of the patients, and the hospital did not have a psychiatric service. The admitting physicians identified 12 of the 100 men as problem drinkers, and 17 additional cases of probable alcoholism were uncovered by the researcher, making a total of 29%.

Only a few studies have been made of the incidence of persons with drinking problems on welfare caseloads, and there is little information on the causal relation between problem drinking and welfare dependency. Problem drinking is found in a sizable proportion - estimates range from 10% to 25% - of the families of welfare recipients (Monthly Report Bulletin, 1964).

Many arrests involve alcohol-related offenses. The impact of problem drinking on the American police-legal system is graphically illustrated by the following figures. In 1965, out of close to five million arrests in the United States for all offenses, over 1,535,000 were for public drunkenness (31%). In addition, there were over 250,000 arrests for driving while intoxicated. Another 490,000 individuals were charged with disorderly conduct which some communities use in lieu of the public drunkenness charge. Thus at least 40% of all arrests are for being drunk in a public place or being under the influence while driving (Uniform Crime Reports, 1965). We do not have any information regarding the portion of identified alcoholics that need or who can profit from rehabilitation services. However, there is evidence that treatment programs which include rehabilitation services are more effective than those which do not. Most alcoholics can be helped when comprehensive treatment programs are available.

THE STATE AGENCY'S ROLE IN REHABILITATION OF THE ALCOHOLIC

The statistics cited above clearly indicate that in order to even begin meeting the needs of this population of impaired individuals, State agencies must utilize all of the resources and creativity at their disposal. In the spring of 1967 a questionnaire was directed to all general rehabilitation agencies regarding their work with alcoholics in FY 1965-66. Twenty-nine agencies responded. The questionnaire and a summary of the responses are presented below:

Questionnaire Regarding Rehabilitation Services Provided Alcoholics: FY 1965-66

1. FOR THE FISCAL YEAR 1965-66, PLEASE CITE THE NUMBER OF REFERRALS FROM THE AGENCIES LISTED BELOW:

Referral Source	Number	Percentage
Courts or Judges	17	0.3%
Probation or Parole	44	0.7
General Hospitals	245	4.0
Private Hospitals	272	5.0
State Mental Institutions	2,271	39.0
Industry or Employer	45	0.8
Psychiatrists in Private Practice	633	11.0
Other Physicians in Private Practice	33	1.0
Ministers	145	2.0
Department of Public Health	362	6.0
Welfare Departments (state and local)	1,521	26.0
Alcoholic Information Centers	143	2.0
Others, Not Elsewhere Classified	140	2.0
Totals	5,871	100.0%

2. HOW MANY CLIENTS WERE ACCEPTED FOR SERVICES IN THE FISCAL YEAR 1965-66 WITH A MEDICAL DIAGNOSIS OF ALCOHOLISM?

(a)	Alcoholism, primary disability	82% (approximately)	N=1,586
(b)	Alcoholism, secondary disability	18% (approximately)	N= 345
		Total	N=1,931

3. PLEASE INDICATE BELOW THE "CLOSED STATUS" DATA FOR ALCOHOLICS FOR THE FISCAL YEAR, 1965-66:

Closed Status

	Closed Referred	Closed Rehab.	Closed not Rehab.	Closed Other
Alcoholism: Primary disability	47% (N=912)	44% (N=852)	6% (N=107)	3% (N=68)
Alcoholism: Secondary disability	40% (N=57)	47% (N=68)	10% (N=15)	3% (N=4)

4. DO YOU HAVE A FORMAL PROGRAM, FACILITY, OR SPECIAL COUNSELOR FOR SERVING THE ALCOHOLIC?
yes 43% (N=10) no 57% (N=13) Total N=23

5. DOES YOUR STATE OPERATE A FACILITY FOR SERVICES TO ALCOHOLICS OTHER THAN UNDER THE DIRECTION OF YOUR AGENCY? yes 70% (N=16) no 30% (N=7) Total N=23

6. DOES YOUR STATE HAVE A COMMISSION OR AN AGENCY DEVOTED TO ALCOHOLISM SERVICES?
yes 77% (N=17) no 23% (N=5) Total N=22

Since only approximately 60% of the agencies responded to this questionnaire, it is difficult to make any conclusive interpretations. However, when we think in terms of 4.5 million alcoholics in the United States, it is quite obvious that we are barely scratching the surface. It is interesting to note that only 33% (N=1,931) of those alcoholics referred to reporting agencies were accepted for services (.00042% of the total number of alcoholics).

In the spring of 1968 a postcard questionnaire was mailed to the 54 general rehabilitation agencies (45 responded) soliciting their state policies regarding providing rehabilitation services to alcoholics. The results are presented below:

Postcard Survey

Questions	Yes Number	No Number
1. Can a VR Client in your state be accepted for VR services with a primary disability of alcoholism?	40 (89%)	5 (11%)
2. Do you have counselors in your state who specialize in working primarily with alcoholics?	22 (49%)	23 (51%)
3. Does your State agency formally participate in any type of treatment setting which specializes in treating alcoholism?	27 (60%)	18 (40%)
4. Do you utilize the category of Extended Evaluation (6 months) in working with alcoholics?	29 (64%)	16 (36%)

These results further indicate the lack of emphasis and effort that rehabilitation agencies as a whole devote to the rehabilitation of alcoholics. Jones (1967) in a recent discussion of this problem drew the following conclusions:

> Failure in rehabilitating the alcoholic client often results from the counselor's not expecting the client to succeed.
>
> Why this dismal prospect, which is communicated so clearly to the client? The best bet, in most cases: the counselor just doesn't know how to help an alcoholic and, consequently, is afraid to really try. This is one of several reasons why most State

> vocational rehabilitation agencies have been reluctant to provide services for alcoholics.
>
> Federal and State requirements are such that it is necessary to produce a certain number of "successful" cases. There is no assurance that this can be done with alcoholics. As a result, counselors almost categorically exclude alcoholics from their caseloads.
>
> Administrative officers say they are not sure alcoholism constitutes a disability, or that eligibility requirements regarding a vocational handicap apply. These fears filter down to the counselor, to help him rationalize his not becoming involved with alcoholics.

It is often assumed that rehabilitation of the alcoholic is prohibitively expensive. Recent statistics published by the Department of Health, Education and Welfare (RSA) do not support this assumption (1968). The following costs are cited:

1. The average cost of rehabilitating an individual during fiscal year 1967 with a disability other than alcoholism was $505.

2. Individuals rehabilitated with a primary diagnosis of alcoholism during the fiscal year 1967 was $361.

The figures cited evidence the fact that there is only one other disability category (digestive system disorders) which costs less to rehabilitate than the alcoholic disability group. With these facts, the reader is encouraged to carefully review the material presented in this report and to consider what can be done to meet the needs of this challenging group of potential rehabilitation clients.

REFERENCES

Bahn, A., & Bahn, A. K. Outpatient psychiatric clinic services to alcoholics, 1959. *Quarterly Journal of Studies on Alcohol*, 1963, *24*, 213.

Bailey, M. Psychophysiological impairment in wives of alcoholics as related to their husbands' drinking and sobriety. In R. Fox (Ed.), *Alcoholism: Behavioral research, therapeutic approaches*. New York: Springer Publishing Company, 1967.

Characteristics and trends of clients rehabilitated in fiscal years 1963-1967. U. S. Department of Health, Education and Welfare, Social Rehabilitation Services, Rehabilitation Service Administration, Division of Statistics and Studies, Washington, D. C., 1968.

Cisin, I. H. Paper presented before American Association for the Advancement of Science, Washington, D. C., December, 1966.

Crime in the United States - Uniform Crime Report, 1965.

Jones, C. C. Vocational rehabilitation of the alcoholic. *Journal of Rehabilitation*, 1967, September-October, 21-22.

Keller, M. Alcoholism: Nature and extent of the problem. *Understanding Alcoholism*, Annals of American Academy of Political & Social Science, 1958, *315*, 1-12.

Monthly Report Bulletin, County of Westchester, New York, Department of Public Welfare, *4* (10), 1964.

Mulford, H. A. Drinking and deviant drinking U. S. A., 1963. *Quarterly Journal of Studies on Alcohol*, 1964, *25*, 634-650.

Chapter II

DEFINITION AND CLASSIFICATION OF THE ALCOHOLIC

The diagnosis of "alcoholism" does not have generic meaning. In fact, it cannot since there is as much variance within a population of alcoholics as the population in general. The excessive consumption of alcohol is frequently the only common denominator. Also, there are many people who have a drinking problem that are not alcoholics. An example would be the man who had always been a light drinker, who is a good husband, father, and employee and who has never been more than slightly intoxicated. However, on one occasion he takes too many drinks, gets into his car, and runs over a pedestrian. Such an individual could not be properly classified as an alcoholic; nevertheless, he has to be considered to have been a problem drinker at that time.

For the purposes of this report, the definition of alcoholism as approved by the American Medical Association was adopted. It is cited in Chapter I. Several other definitions have appeared in the literature and are offered to point out the similarities and differences recognized by the various workers in the field of alcoholism. A sampling of these appears below:

> Any use of alcoholic beverages that causes damage to the individual or society or both (Jellinek, 1960, p. 35).
>
> Alcoholism is a chronic disease, or disorder of behavior, characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or ordinary compliance with the social drinking customs of the community, and which interferes with the drinkers health, interpersonal relations or economic functioning (Keller, 1958, p. 2).

> Alcoholism is a chronic disease manifested by repeated implicative drinking so as to cause injury to the drinker's health or to his social or economic functioning (Keller, 1960, p. 133).
>
> Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their inter-personal relations, and their smooth social and economic functioning; or who show the prodromal signs of such development (World Health Organization, 1966).

CLASSIFICATION OF THE ALCOHOLIC

An adequate operational classification system of alcoholics would be of considerable benefit to lay and professional people in accelerating the process of case finding, diagnosis, treatment, arriving at a prognosis, and eventually the rehabilitation of the alcoholic. The multifaceted nature of the problem has hindered the development of a refined and highly reliable system. Of historical interest is E. M. Jellinek (1960, p. 35) and the manner in which he dealt with the problem in his book entitled *The Disease Concept of Alcoholism*. He stated that there is no single "alcoholism" but many different "alcoholisms." The following is Jellinek's classification of "alcoholisms":

1. *Alpha Alcoholism* - represents a *purely* psychological *continual* dependence or reliance upon the effect of alcohol to relieve bodily or emotional pain. The drinking is "undisciplined" in the sense that it contravenes such rules as society tacitly agrees upon - such as time, occasion, locale, amount, and effect of drinking - but does not lead to *loss of control or inability to abstain*. There

may be interference with the family budget, occasional absenteeism from work and decreased productivity and some of the disturbances due to withdrawal of alcohol. Nor are there any signs of a progressive process.

2. Beta Alcoholism - is that species of alcoholism in which such alcohol complications as polyneuropathy, gastritis, and cirrhosis of the liver may occur without either physical and psychological dependence upon alcohol. The incentive to the heavy drinking that leads to such complications may be the customs of a certain social group in conjunction with poor nutritional habits. The damage in this instance is of course the nutritional deficiency diseases, but impaired family budget and lowered productivity as well as a curtailed life span may also occur. Withdrawal symptoms, on the other hand, do not emerge.

   Beta Alcoholism may develop into gamma or delta alcoholism, but such a transition is less likely than in the instance of alpha alcoholism.

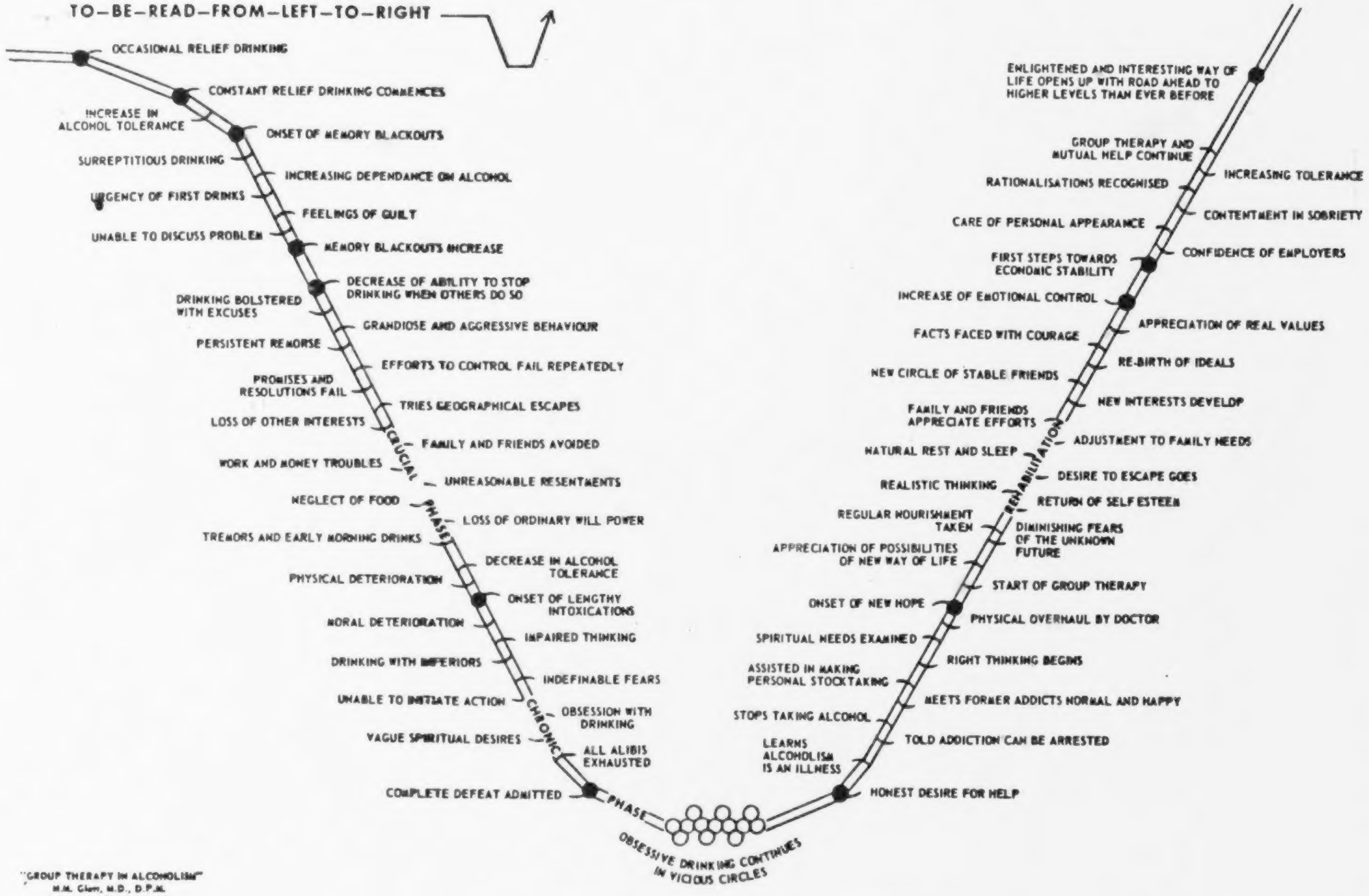
3. Gamma Alcoholism - is apparently the predominating species of alcoholism in the United States and Canada, as well as in other Anglo-Saxon countries. It is what Alcoholics Anonymous recognize as alcoholism to the exclusion of all other species.

   Gamma Alcoholism means that species of alcoholism in which (1) acquired increased tissue tolerance to alcohol, (2) adaptive cell metabolism, (3) withdrawal symptoms and "craving" i.e., physical dependence, and (4) loss of control are involved. In gamma alcoholism there is a definite progression from psychological to physical dependence and marked behavior changes. Alpha and beta alcoholism may develop under given conditions into gamma alcoholism.

This species produces the greatest and most serious kinds of damage. The loss of control, of course, impairs interpersonal relations to the highest degree. The damage to health in general and to financial and social standing are also more prominent than in other species of alcoholism.

4. Delta Alcoholism - shows the first three characteristics of gamma alcoholism as well as a less marked form of the fourth characteristic - that is, instead of loss of control, there is inability to abstain. In contrast to gamma alcoholism, there is no ability to "go on the water wagon" for even a day or two without manifestation of withdrawal; the ability to control the amount of intake on any given occasion, however remains intact. The incentive to high intake may be found in the general acceptance of the society to which the drinker belongs.

According to Jellinek, we in America are primarily concerned with treating the gamma alcoholic which he considers the most difficult of all to treat and the most damaging to the individual and society if untreated. The gamma and delta types are the only two types of alcoholism he considers to have all the characteristics of a disease. The following chart illustrates the phases of addiction to recovery:


TO-BE-READ-FROM-LEFT-TO-RIGHT
OCCASIONAL RELIEF DRINKING
CONSTANT RELIEF DRINKING COMMENCES
INCREASE IN ALCOHOL TOLERANCE
ONSET OF MEMORY BLACKOUTS
SURREPTITIOUS DRINKING
INCREASING DEPENDANCE ON ALCOHOL
URGENCY OF FIRST DRINKS
FEELINGS OF GUILT
UNABLE TO DISCUSS PROBLEM
MEMORY BLACKOUTS INCREASE
DECREASE OF ABILITY TO STOP DRINKING WHEN OTHERS DO SO
DRINKING BOLSTERED WITH EXCUSES
GRANDIOSE AND AGGRESSIVE BEHAVIOUR
PERSISTENT REMORSE
EFFORTS TO CONTROL FAIL REPEATEDLY
PROMISES AND RESOLUTIONS FAIL
TRIES GEOGRAPHICAL ESCAPES
LOSS OF OTHER INTERESTS
CRUCIAL
FAMILY AND FRIENDS AVOIDED
WORK AND MONEY TROUBLES
UNREASONABLE RESENTMENTS
NEGLECT OF FOOD
PHASE
LOSS OF ORDINARY WILL POWER
TREMORS AND EARLY MORNING DRINKS
DECREASE IN ALCOHOL TOLERANCE
PHYSICAL DETERIORATION
ONSET OF LENGTHY INTOXICATIONS
MORAL DETERIORATION
IMPAIRED THINKING
DRINKING WITH INFERIORS
INDEFINABLE FEARS
UNABLE TO INITIATE ACTION
CHRONIC
OBSESSION WITH DRINKING
VAGUE SPIRITUAL DESIRES
ALL ALIBIS EXHAUSTED
COMPLETE DEFEAT ADMITTED
PHASE
OBSESSIVE DRINKING CONTINUES IN VICIOUS CIRCLES
HONEST DESIRE FOR HELP
LEARNS ALCOHOLISM IS AN ILLNESS
TOLD ADDICTION CAN BE ARRESTED
STOPS TAKING ALCOHOL
MEETS FORMER ADDICTS NORMAL AND HAPPY
ASSISTED IN MAKING PERSONAL STOCKTAKING
RIGHT THINKING BEGINS
SPIRITUAL NEEDS EXAMINED
PHYSICAL OVERHAUL BY DOCTOR
ONSET OF NEW HOPE
START OF GROUP THERAPY
APPRECIATION OF POSSIBILITIES OF NEW WAY OF LIFE
DIMINISHING FEARS OF THE UNKNOWN FUTURE
REGULAR NOURISHMENT TAKEN
RETURN OF SELF ESTEEM
REALISTIC THINKING
DESIRE TO ESCAPE GOES
REHABILITATION
NATURAL REST AND SLEEP
ADJUSTMENT TO FAMILY NEEDS
FAMILY AND FRIENDS APPRECIATE EFFORTS
NEW INTERESTS DEVELOP
NEW CIRCLE OF STABLE FRIENDS
RE-BIRTH OF IDEALS
FACTS FACED WITH COURAGE
APPRECIATION OF REAL VALUES
INCREASE OF EMOTIONAL CONTROL
FIRST STEPS TOWARDS ECONOMIC STABILITY
CONFIDENCE OF EMPLOYERS
CARE OF PERSONAL APPEARANCE
CONTENTMENT IN SOBRIETY
RATIONALISATIONS RECOGNISED
INCREASING TOLERANCE
GROUP THERAPY AND MUTUAL HELP CONTINUE
ENLIGHTENED AND INTERESTING WAY OF LIFE OPENS UP WITH ROAD AHEAD TO HIGHER LEVELS THAN EVER BEFORE

"GROUP THERAPY IN ALCOHOLISM"
M.M. Glatt, M.D., D.P.M.
Warlingham Park Hospital

A CHART OF ALCOHOL ADDICTION AND RECOVERY

Reprinted from the British Journal of Addiction, 54 (2).

The symptoms shown by a person with alcoholism will not necessarily occur in the sequence shown. The phases of recovery may commence at any point on the continuum.

Dr. Vernelle Fox, Medical Director of the Georgian Clinic in Atlanta, Georgia, assisted by Dr. George Lowe, University of Georgia, Department of Sociology, has developed a different type of classification scheme based on their experience (1968). Doctors Fox and Lowe have attempted to deal more with the causative factors as opposed to emphasis on the symptoms. The majority of the alcoholics classified under their system could be considered "gamma alcoholics" in Jellinek's scheme. Doctors Fox and Lowe feel that most of the alcoholics they see fit one of the following five categories:

I. Situational Drinkers (rare in civilian life), i.e., people in the military.

II. Drinking, addictive or non-addictive, as a means of compensating for:

  A. Mental retardation.
  B. Organic brain damage.
  C. Gross social deprivation.
  D. Severe psychosis.

III. Biological Abreactors (abnormal metabolism of alcohol - probably not frequently seen in vocational rehabilitation office).

IV. Addictive drinking because of gross role changes, i.e., divorce or wife dying.

V. Addictive drinking as a means of adjusting (his personality and patterns of relating) to:

  A. Immature personality - unable to relate effectively to own age group.

  B. Hostile-dependent personality
    1. Agressive - predominantly agressive in relating to others.

2. Passive - predominantly passive in relating to others.

C. Depression
1. Chronic - is depressed most of the time.
2. Cyclic - periodic cycles of depression.

D. Anxiety
1. Chronic - is anxious most of the time.
2. Cyclic - periodic cycles of extreme tension.

Some degree of brain damage may be present in any or all of these categories. The authors feel that most of these are reversible with appropriate treatment. However, they also recognize that some are not.

The American Psychiatric Association has recently revised their Diagnostic and Statistical Manual of Mental Disorders (1968). The new revision provides for a clearer delineation of diagnoses of drinking problems and should facilitate accumulation of research data and prognosis for treatment. The new classification is as follows:

> 303 Alcoholism
>
> This category is for patients whose alcohol intake is great enough to damage their personal or social functioning, or when it has become a prerequisite to normal functioning. If the alcoholism is due to another mental disorder, both diagnoses should be made. The following types of alcoholism are recognized:
>
> 303.0 Episodic excessive drinking
>
> If alcoholism is present and the individual becomes intoxicated as frequently as four times a year, the condition should be classified here. Intoxication is defined as a state in which the individual's

coordination or speech is definitely impaired or his behavior is clearly altered.

303.1 Habitual excessive drinking

This diagnosis is given to persons who are alcoholic and who either become intoxicated more than 12 times a year or are recognizably under the influence of alcohol more than once a week, even though not intoxicated.

303.2 Alcohol addiction

This condition should be diagnosed when there is direct or strong presumptive evidence that the patient is dependent on alcohol. If available, the best direct evidence of such dependence is the appearance of withdrawal symptoms. The inability of the patient to go one day without drinking is presumptive evidence. When heavy drinking continues for three months or more, it is reasonable to presume addiction to alcohol has been established.

SUMMARY

Obviously, these are gross classification systems, and the lines are never very clear-cut. For example, all patients manifest anxiety and/or depression at one time or another. These categories are meant to give only broad concepts of the appropriate treatment attitude and expectation of outcome. Since the etiology and epidemiology of this group of disabilities are not yet known, it is imperative that the rehabilitation counselor evaluate each client in terms of the assets and liabilities the person brings with him, the counselor's potential assets, and sources of help that can be mobilized in each particular situation.

REFERENCES

Diagnostic and statistical manual on mental disorders. (Rev. ed.) Washington, D. C.: American Psychiatric Association, 1968.

Fox, V. Speech delivered at IRS, 1968 Workshop on Rehabilitation of the Alcoholic, Athens, Georgia, October 25, 1967.

Jellinek, E. M. *The disease concept of alcoholism.* New Haven: Hillhouse Press, 1960.

Keller, M. Alcoholism: Nature and extent of the problem. In *Understanding Alcoholism.* *Annals of the Academy of Political and Social Science*, 1958, *315*, 1-11.

Keller, M. Definition of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1960, *21* (1), 125-134.

Chapter III

THE NEEDS OF THE ALCOHOLIC

Dr. Vernelle Fox is Medical Director of the Georgian Clinic in Atlanta, Georgia. This facility specializes in treating the alcoholic utilizing the therapeutic community approach. In this chapter, she discusses those problems and special needs presented by the person suffering from alcohol addiction and the barriers which often obscure an adequate understanding of the disability. Dr. Fox emphasizes that a clear understanding of the special needs of the alcoholic is mandatory if successful rehabilitation is to be accomplished.

Addiction, physical and/or psychological, to alcohol and/or sedatives is a medical disease that can occur in all kinds of people. Very little has been learned about the physiological mechanism of "loss of tolerance," but early evidence points to a process not too dissimilar to diabetes. While the "missing link" is not insulin and the primary site not the pancreas, the principle is probably the same. It is likely that liver alcohol dihydrogenase and the liver are most involved. Theoretically, a certain percent of people will lose their ability to correctly metabolize alcohol after sufficient exposure. If the diabetic model is correct, the amount of exposure needed to precipitate clinical symptomatology will vary appreciably.

Once the individual has lost his tolerance for and ability to adequately metabolize alcohol, the stage is set for a wide range of medical complications, nutritional deficiencies, et cetera.

The basic physiological disease is greatly complicated and confused by the ambivalence in our society about drinking. This ambivalence and resulting judgmental attitudes set the stage for denial of disability and rapidly increasing interpersonal struggles, both of which contribute to prolonging the illness. Unfortunately, as previously stated, addiction occurs in all kinds of people. Some are fairly well integrated, socially and economically stable, and motivated to be healthy. For these patients, medical treatment with some continuing support may be enough. The major problems arise when the addiction occurs in individuals who are disturbed in any or all related areas. Special continuing difficulties can be expected if the individual has a need to remain sick.

So it is of utmost importance to look at "what kind of person" has developed alcohol addiction in order to know what will be necessary to help him achieve and maintain an improved state of health.

The questions are often appropriately asked, "What is the difference in the needs of these clients and the requirements for adequate services for the alcoholic and other disturbed patients?" "Why can't they be treated in the same program as other adult psychiatric patients?" There are many similarities between these groups of patients, but alcoholics have very specific needs that necessitate special approaches if treatment is to be effective. The following chart outlines these needs.

PROBLEMS

What is unique about the alcoholic?

1. Drinking is his solution to his disability.
2. Medical complications usually present.
3. Uses drinking behavior to hide primary disability.
4. Has ambivalence about commitment to life or death.

NEEDS

What are the special services needed by the alcoholic?

1. Continuously available peer or reference group.
2. Medical management of acute and chronic disabilities.
3. Awareness of the fact that he uses drinking behavior to hide primary disability.
4. Help in facing up to his lack of commitment to life or death.

BARRIERS

What are the barriers to providing these services?

1. Society's ambivalence about drinking.
2. Lack of know-how in using existing treatment aids.
3. Previous poor experiences associated with alcoholics and lack of awareness that drinking behavior is being used to hide primary disability.
4. Pressure for production on rehabilitation counselors and other helpers.

The person with alcoholism differs from other disturbed clients in four major ways, and these dictate the special services needed and give us the clues to the barriers to providing these services. The meanings of many of these concepts are obvious; others need some elaboration.

Problem 1. Drinking is his solution to his disability. His consumption of alcoholic beverages and/or other mind modifying chemicals is not drinking in the usual concept. It is his attempt to compensate for his primary psychological disability. He is caught up in a destructive pattern of self-medication. He swallows these various chemicals in an attempt to relieve the symptoms, anxiety and/or depression, created by his primary disability. He is a fragmented person and develops an identity as a drinking problem. In most instances, this mechanism, even with its problems and unhappy side effects, is, from his viewpoint, the only conceivable solution. He sees only three choices - go crazy, commit suicide, or get drunk. If these were, in fact, his only choices, he has made a wise decision. The difficulty is that this compensatory mechanism breaks down eventually.

He usually seeks help at this time. The manner in which he presents his need may well be so ambiguous that the rehabilitation counselor will not get the true message. He frequently refers only to his "nerves," his job problems, home situation, et cetera. He is not likely simply to state that he has been drinking addictively as a means of adjustment.

Need 1. Continuously available peer or reference group. His special need to combat this manifestation of his illness is a continuously available reference group. By this, we mean a peer group with whom he can begin to identify. Having established an identity as a drinking problem and knowing only one way (the consumption of chemicals) to handle his discomfort presents a major hurdle from the beginning. It is well established that people learn better from their peers rather than their authority figures, and it seems unrealistic for the rehabilitation counselor to try to work with this client without the help of a reference group. Recovery from alcoholism is always a long, slow (several years) re-learning process; and the individual will have to repeatedly recheck his new identity as a person with problems, struggling to live without sedative chemicals. Many such reference groups are available. Almost every community has an active Alcoholics Anonymous group within commuting distance from the average client. It may take a little effort on the part of the counselor to get the patient in touch with an appropriate sponsor, and he may even have to take him to some meetings. Also, in many communities, there are clinics, rehabilitation residences, and other organized services that provide these peer groups. On the surface, this may not seem to be a valid function for rehabilitation counselors, but this relatively small amount of effort can conserve vast amounts of energy in opening and closing cases as well as "follow-up" concerns.

Barrier 1. Society's ambivalence about drinking. What is the major difficulty in utilizing available reference groups? It is the prevalent ambivalence in our society regarding drinking! Our mixed feelings regarding the "good or bad" of drinking per se, as well as our lack of awareness that addiction is quite different from social drinking, make us disregard the length of time that is necessary for these clients to become stabilized in a new way of life. We are quite inclined to fall for the idea that if the alcoholic stops drinking, this solves all his problems. When speaking of society's ambivalence about drinking, it is necessary to remember that rehabilitation staff members from top to bottom are members of society. They were people with all of these ambivalences long before they became associated with the rehabilitation programs. It behooves the people of any program that professes to work with addictive drinkers to take an honest look at their own ability to see the person behind the bottle as well as the fact that the effects of alcohol are different physiologically and psychologically in this group than in other people.

Problem 2. Medical complications usually present. Almost without exception, the individual has developed medical complications by the time he seeks help. This is not true for most other clients with psychiatric disabilities. Some people who manifest medical complications of alcoholism react abnormally to alcohol from the beginning. They become quite ill following the ingestion of relatively small amounts of the chemical. Frequently, their medical disabilities are indistinguishable from those produced by the ingestion of huge amounts taken over long periods of time.

Need 2. Medical management of acute and chronic disabilities.
It is important to view the patient's medical disability, not necessarily his drinking history alone, and to provide adequate medical management for all disabilities found. More is said about this in Chapter V of this report; however, acute and chronic detoxification and the treatment of all allied disabilities is the essential first step in services to these clients.

Barrier 2. Lack of know-how in using existing treatment aids.
Why should the most obvious and, frequently, most obtainable portion of a rehabilitation program for this group be a problem? There are two major reasons. In trying to grasp the broadness of this illness, we are inclined to look to the behavioral sciences for explanations. While these are most useful in our understanding of the total problem, they usually do not include consideration of the physical disabilities. Behavioral sciences tend to see only the drinking behavior. This, added to our own ambivalence about drinking, tends to prevent us from looking for the purely medical aspects of the client's problem. If we are not looking at this part of his disability, we do not seek out these sources of help for him. A great deal more in technical knowledge and potential services are available in various communities than are utilized. The rehabilitation counselor is in a more unique position to "require" diagnostic and therapeutic

services than are members of most other helping professions. If the rehabilitation counselor requests certain physical and laboratory examinations for clients from their physicians, the information will likely become available (see Chapter VI).

Problem 3. Uses drinking behavior to hide primary disability.
The addictive drinker uses his drinking behavior to hide his primary disability in many cases. It is not only easier for the client and those around him to see his drinking behavior, it is also much less threatening. They have all learned some means of coping with this behavior. This coping mechanism may be quite disabling and unsatisfactory, but at least it is familiar. The underlying physical and/or psychological problems are vague and frightening. People's need to comprehend things and fix responsibility for results perpetuates this oversimplification.

Need 3. Awareness of the fact that he uses drinking behavior to hide primary disability.
The special need in this area is for the rehabilitation counselor to be aware of the fact that this is a complex illness and that everything will not automatically "be all right" if the alcoholic stops drinking. While abstinence is the essential first step in the alcoholic's recovery, it is only the beginning. It takes a well-worked out, long-range, flexible plan to correct medical problems, support the individual's motivation for health, help him develop new patterns of adjustment, and reestablish communications with the significant people around him.

Barrier 3. Previous poor experiences associated with alcoholics and lack of awareness that drinking behavior is being used to hide primary disability.

These needs are met with a greater degree of frequency for other chronic disability groups. The techniques and services needed are often modifications of ones already used by experienced counselors. What precludes their delivery to this target group? One of the most likely explanations is the counselor's previous poor experience in working with alcoholics. If he has failed to see the complexity of the problem , been caught by the client's ability to fragment all help offered him, and expected rapid and almost miraculous results because the individual got sober, he has been disappointed and frustrated. Having failed to really recognize that the drinking behavior is a mask for the underlying disability, we have had unrealistic expectations which result in frequent failures. This sets a negative climate for working with the next client.

Problem 4. Has ambivalence about commitment to life or death.

Behind all these special problems and needs of the addictive drinker is his most unique difference. He has an ambivalent commitment both to life and to death. The vast majority of people in helping professions are fairly well integrated, committed to living, and find this concept difficult to comprehend. It is easier to understand an individual who is basically committed to death. His behavior is consistently self-destructive. The person with alcoholism does not have this consistence. His manifest drive is toward health at one time and toward sickness at another. Initially, he is quite unaware of this ambivalence and quite incapable of understanding his own changing behavior. He is not lying when he says he will "never do that again." At the time, he is committed to living and feels this. He is unaware that this commitment is not lasting, that he will ultimately have an even stronger desire to retreat from life, and that his behavior will be dictated by these destructive impulses.

Need 4. Help in facing up to his lack of commitment to life or death.

His special need in this area is to help recognize this ambivalence in order for him to be more able to control his self-destructive periods. To accomplish this, he needs someone outside himself who is capable and willing to be supportive, i.e., a continuing follow-up relationship with his counselor. It also speaks to the futility of expecting a prosthesis or a training experience alone to solve the problem.

Barrier 4. Pressure for production on rehabilitation counselors and other helpers.

This is a time-consuming process that does not lend itself to "quick closures." If rehabilitation programs are to provide meaningful services to this complex disability group, it will be necessary for the individual counselors to take all these factors into careful consideration. It will be even more necessary for supervisors and agencies to re-evaluate their expectations of the counselors working with these clients. Standards should be set as to numbers on case loads, time of closures, etc., that take into account the true nature of this disability, and the services needed to combat it.

Chapter IV

ELIGIBILITY AND FEASIBILITY CONSIDERATIONS

Eligibility and feasibility considerations are of special importance when considering alcoholic clients. The requirements for acceptance for services can usually be interpreted broadly enough to provide services or so stringently as to exclude services to this disability group. The ultimate decision is usually left to the counselor's discretion and his interpretation of program regulations.

Before accepting any applicant for service, the rehabilitation counselor is required to establish that:

1. The individual has a physical or mental disability.
2. A substantial handicap to employment exists.
3. There is a reasonable expectation that rehabilitation services may render the individual fit to engage in a gainful occupation.

The third criterion is concerned primarily with vocational prognosis. Rehabilitation agencies exist, "to assist personally and economically dependent individuals with impairments (physical, mental, emotional, educational, cultural, etc.) in the achievement of the highest level of personal and economic independence possible."* This does not mean that it must be determined that every applicant will eventually be able to work on a full-time job. It does mean that improvement in ability to function is a goal of the State rehabilitation agency and that services are offered in order to assist impaired individuals in their efforts to attain the highest possible level of independence.

A few reasonable questions to ask in regard to the prospective alcoholic client would be:

1. "Is this person feasible for rehabilitation services?"

2. "Will he be able to profit from services rendered?"

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* Porter, T. Speech delivered at IRS, 1968 Workshop on Rehabilitation of the Alcoholic, Athens, Georgia, October 25, 1967.

3. "Can he participate in a rehabilitation program that places emphasis on his vocational potential... and, if he does, is there at least a fair chance that the end result will be a productive person who receives personal and economic benefit from his own productivity?"

A man may be too disabled to be eligible for rehabilitation services, or he may not be disabled enough to be eligible. The rehabilitation counselor must determine the eligibility of each applicant; and once he determines that a substantial handicap for employment exists, his next task is to decide whether or not the barrier that lies between the applicant and employment can be removed or markedly reduced. This latter task is often referred to as "determination of feasibility."

Legal Considerations

Current Federal Regulations (1966) emphasize that "no group of individuals shall be excluded or found ineligible on the basis of their type disability (Section 401.20)." Therefore, it is clear that medically diagnosed alcoholics do in fact meet the first criterion for eligibility, i.e., "the presence of a physical or mental disability."

Alcoholism or Problem Drinking?

Social stigma and legal considerations often preclude physicians' use of the diagnosis of "alcoholism." The diagnosis of "problem drinker" or "excessive drinker" is frequently substituted by the consulting physician. For the rehabilitation counselor, this procedure frequently confuses the question of eligibility. In reference to this question, Mr. William A. Crunk, Associate Regional Commissioner for Rehabilitation Services, offers the following interpretation of the Federal Regulations:

> The individual (alcoholic or problem drinker by diagnosis) whose drinking was substantially interfering with his work or in the counselor's judgement would lead to substantial work interference would, therefore, have an impairment and would meet the first criteria

of eligibility. The question remaining then to be resolved is: Does he have a medical impairment which may be certified by a physician or does he have a behavioral disorder which additionally requires validation by a psychiatrist or psychologist? On technical professional questions of this sort auditors will not challenge the counselor's judgement as long as it remains within reason. There is a broad continuous spectrum between what might be called medical and what might be termed behavioral impairment in individuals who are troubled with alcohol, and auditors will allow wide flexibility as to where the line should be drawn.

I would favor promoting very substantial flexibility to be exercised by the counselor so that his judgement as to whether psychiatric or psychological consultation is needed is an important consideration in classifying the case. A well-informed counselor who takes a careful history will do better than any formula we can develop for choosing which person should be classified as an addicted alcoholic or one with a behavioral disorder and seen by a psychiatrist or psychologist. The exact terms as used by the physician can safely be disregarded as a Federal audit factor.

Therefore, as you can see from the foregoing, this office does not feel that we have either a legal or an audit question regarding the actual diagnosis given by a physician, provided that the sum total of the diagnostic information including the counselor's case history indicates that we have an addicted alcoholic. I mention the behavioral disorder as an eligibility factor only for those cases where there is substantive questions as to addiction or not. In my judgement, many of these would be eligible because of behavioral disorders.

With many applicants, the question of feasibility is not too difficult to answer. If a man can't work because of a physical impairment, the limitation can be repaired; and, generally, there is good reason to believe that the man will be able to return to work following surgery and a period of convalescence. In many cases where physical restoration services are needed, the medical specialists involved can usually predict when the client can return to work. Some illnesses, diseases, and disabilities lend themselves very readily to objective examination.

As rehabilitation counselors began to work with the emotionally ill individuals, certain changes in client evaluation became necessary. The *person* himself, rather than some injured portion of that person, became the primary object of the evaluation. The effect of that person on other people and their effect on him should be recorded in case histories as significant information. Counselors began to rely more on their own impressions and reactions to their clients. These feelings about alcoholic clients are important in evaluating the client's over-all limitations, strengths, capacity to respond to helping services, and ability to participate in their own rehabilitation. Accordingly, it is important that counselors examine *themselves* and their own limitations and strengths more carefully, for their personal feelings about their clients are of importance in evaluating these people.

What is different about the alcoholic? What makes his evaluation difficult to the point of requiring a special study such as this one? Here are a few of the reasons why feasibility determination for alcoholics is particularly troublesome:

1. *"He" is not one, but many.*
   Physical and/or emotional addiction to alcohol is found in all kinds of people. Alcoholics are different from one another. A counselor may feel that he has some understanding of the alcoholic he saw last week, but the woman sitting in front of him now just isn't the same. Those in treatment centers say there is no such thing as "alcoholism" and talk about the many "alcoholisms." Alcoholics present themselves to other people in many ways and have

myriad reasons why they drink. Their own proposed solutions to their addictions are equally diverse, and the counselor who attempts to use a single evaluation theory or approach is going to meet considerable frustration.

2. Loss of ability to communicate meaningfully with other people.
Since alcohol is frequently the alcoholic's most effective way of "saying" something to people around him and of relieving the pain caused in part by lack of meaningful communication, he suffers from his lack of ability to "get through" to others. Like a musical instrument capable of producing only one monotonous sound, he becomes difficult to listen to. At the same time, he comes to expect only limited communication from others. Many have a ponderous amount of advice to give him; but since much of it came in the form of sterile words without any sharing of the advisor's self, he has learned to "tune-out" this kind of help. It is difficult for him to imagine anyone who can hear his pain without anxiously responding with prefabricated answers and solutions. Typically, he doesn't trust people; and he seemingly is more concerned with "getting something from them" than in genuinely relating to them. His ability to participate in mutual sharing with other persons is severely impaired. It is difficult to evaluate a man who cannot hear with meaning.

3. He often is found in the midst of a variety of crises which must be dealt with before the evaluator can begin to know the alcoholic himself.
Generally his teeth have been ignored for years and made worse by an inadequate diet. He needs dental attention before he can concentrate on other needs or on what the counselor is saying. His children need help and that has to come first. He has lost his driver's license and can't keep his appointments with any regularity...and how can he return to sales work without a driver's license? His wife is divorcing him, and he suspects she is running around with another man. He tries

to direct all of his energy toward holding his family together. He is due in court next week due to a property damage suit, and he may go to jail. His creditors are "ganging-up" on him, and he has to find some way to satisfy them immediately. Into these problems steps the rehabilitation counselor as a "helping" person. Is it any surprise that those who work intensively with alcoholics usually do so as a team and try to discourage any counselor from working with an alcoholic only on a one-to-one basis? Any one person can be overwhelmed by the many acute needs of the alcoholic.

4. He is often unrealistic in assessing his own aptitudes and skills and in setting suitable goals for himself; yet, in spite of this, he tends to "know what he wants" and to be very persuasive in selling his own distorted appraisal of himself to others.

   An alcoholic's picture of himself as an able workman, a good employee ("when I'm sober!"), is one of the last distorted images he relinquishes. In giving his work history, he may proudly state that he has never been fired but neglects to mention the times he quit just before being fired or the times he was retained by a patient employer when he should have been fired.

   A great many alcoholics bring only one of two commonly heard requests to a rehabilitation counselor: (1) help me to get a job and (2) help me to get training. The applicant makes these requests quite firmly and expects the counselor to either say yes or no immediately. Any attempt on the counselor's part to evaluate such requests against the applicant's social, educational, medical, and work background is apt to be met with bewilderment or anger.

   Frequently, attempts by the counselor to "get to know" the applicant, to simply "be" with him over a period of time, may be perceived as a threat or an irrelevant and unnecessary waste of time. He knows what he wants "if the counselor would only listen."

5. He is impatient, seeks immediate rewards for his efforts, and is uncomfortable with long-term goals. He not only knows what he wants, he knows he wants it now! When the alcoholic begins to try to live without alcohol, he usually doesn't simultaneously give up his need for quick solutions. He may not see that his addiction is not only to alcohol but to easy answers as well. In fact in giving up alcohol his attention may be drawn even more acutely to other needs, and he may honestly feel that these other needs must be satisfied without delay if he is to remain sober. He will have great difficulty understanding why people do not respond immediately when he makes a "sober" request. The amount of pressure that such an applicant can put on a counselor can be appreciated only by those who have encountered this force. It can be extremely effective in producing one of two results (1) in making the counselor give what is being requested without proper evaluation or (2) in causing the counselor to reject the request and the client entirely.

6. He can be particularly adept in his use of "denial of reality" as a defense against pain and as an instrument by which he avoids meaningful contact with people.

   For example, he may have convinced himself that all he has to do is stop drinking and everything will be rectified. All of the various hurts he has inflicted and received will be healed, and his life will snap back to normal again automatically with sobriety. Denial works to prevent his seeing just how much damage has really been done and how much emotional sweat it will take to restore things to normalcy. Denial is present in the self-confident renunciation of alcohol by the "one-week-sober alcoholic," who knows that he will never drink again. Then, there is the client who denies that he has ever had or will ever have a serious problem with alcohol even though his life is full of evidence pointing to his uncontrollable drinking. Such denial isolates the person and separates him from people who might be of help in his rehabilitation. It is difficult to relate to a person in need who cannot express his loneliness and pain. Some clients admit freely that they are an alcoholic and that because they are and the counselor is not, there can be no real rapport between them. The idea that, "It takes an alcoholic to help an alcoholic," is a popular expression among this group. In some cases this view is held so tenaciously that there appears to be a rejection of all others; alcoholism becomes a cult. That is, the alcoholic denies that he has anything meaningful in common with non-alcoholics. Many such persons are able to stay sober and lead useful lives within their relatively closed society of alcoholics. But, as with the others who rely heavily on the defense of denial, it is extremely difficult to evaluate them for rehabilitation services. The defense that protects them from an overload of pain "protects" them also from certain structured forms of help, such as the public agency with its policies, procedures, and formal evaluations.

7. His level of functioning is not congruent with his potential as measured by psychometric instruments.

   It is not uncommon for trained and experienced professionals to be misled by the apparent abilities of an alcoholic. This particularly is true if he is physically attractive, talks rather freely and spontaneously, and has a considerable amount of personal warmth. It is generally accepted that these clients tend to be unusually adept in their ability to manipulate people and to "have their way" in their relations with other people. Unfortunately, his manipulative skills often succeed in acquiring for him those objects, situations, and relationships, that tend to destroy him rather than help him.

   It is important for those professional persons who attempt to evaluate this client to remember that his functional intelligence may be less than it is reported or appears to be. Many addicted persons have not had substantial vocational training. There are gaps in their training that leaves them relatively insecure vocationally and vulnerable in a changing world of work. It is important that the client recognize his vocational inadequacies and seek realistic solutions to his job problems rather than pretend to be ready for employment.

Of course, there are some alcoholics who are as skilled as they appear to be and who may need only a period of sobriety before returning to employment. This is precisely the problem: It is usually not easy to determine in a short period of time whether the client's presentation of himself is the real self or a facade. His expressed desire to "get sober and get back to work as soon as possible" may sound like good motivation to a rehabilitation counselor, but such an expression may be just an attempt by the client to win acceptance from the counselor (whom he *knows* is work-oriented) in order that some other objective might be attained by the applicant. Also, it could be an attempt to hide from himself the true severity of his disability. He may not be ready to accept just how sick he is or to recognize his underlying need to be sick.

8. *The extent to which his family is involved in, and perhaps contributing to, his alcoholism is difficult to determine, but extremely important.* If there is a family in the picture at all, alcoholism and alcoholic rehabilitation is a family matter. If the client makes progress, it usually is accompanied by a healthier attitude on the part of the family. If he fails to respond to treatment, the family often is contributing to his failure in some way.

The family may be confused and afraid, angry or silently resistive when a counselor attempts to talk with them about the client's drinking problem. They may feel that his problem is, indeed, his problem and that to involve them is not appropriate. They may be greatly embarrassed over the whole matter and want to ignore it as much as possible. Regardless of the way in which the family responds outwardly to their being included in the evaluation, the counselor can be sure there are intense feelings about the destructive drinking of the alcoholic member. It is not unusual for one or more members of the family to be very confused over just what the counselor or treatment team is trying to do with their addicted member. They may feel that the counselor is being too "sympathetic" to the problems of the client and become rather suspicious of the whole helping effort. They can be expected to react quite strongly when the client "slips" and drinks after entering a treatment program. The counselor may find himself spending more time, and getting more involved, with the family than with the alcoholic...and, depending on the circumstances, this may even be the best approach. There are cases on record in which the spouse of an alcoholic sought help for her problems, and the husband stopped drinking as a result of the spouse's progress in therapy, even though he sought no treatment for himself. Also, there is clinical evidence to support the belief that some women, and some men, find it easier to live with a drunk spouse than a sober one. In subtle, and some not-so-subtle ways, such persons will arrange to keep their spouses intoxicated a great deal of the time. A woman who enjoys being the wage-earner, and finds it more comfortable to live with a bottle than an apron, can be very threatened by any attempt to rehabilitate her husband.

Alcoholism usually develops rather slowly in a person over a period of years. As it develops in a family, a structure develops along with it...a system for coping with the drinking member. Each family member learns his or her "role" in respect to the drinking behavior. When any helping person attempts to intervene and enter this structure for the purpose of bringing change, he should remember all of the interrelationships involved.

In discussing the "family" of the alcoholic, it should be understood that everything said in this section may apply equally to all "significant others" in his life. These significant others may include his employer or supervisor, his landlady, or even such persons as his welfare worker or probation officer. Viewed from this perspective, a larger number of this group will be seen to have a substitute family still intact, still influencing them, and being influenced by them. This kind of thinking also tends to throw new light on the lack of interagency cooperation. Such lack of cooperation now may be seen as a very personal "family squabble" where much more is involved than just agency policy and regulations and where the participants are seen to be more than just professionally involved. To repeat, rehabilitation is a family matter.

9. *The counselor needs help in determining feasibility. A team approach is needed, yet this kind of approach presents problems in itself, apart from the problems presented by the client being evaluated.*
Most alcoholics tend to be too manipulative, too dependent, too angry, too fragmented, and, in general, too draining of other people's personal and professional resources to be adequately evaluated by any one person. A counselor needs other professionals with whom he can compare impressions and share experiences. Most addicts have an amazing ability to make any one person feel important; and after promoting a counselor to that position, he can make that same counselor feel like an absolute louse if he refuses to comply with his demands. He says, in effect, "You can help me by just doing such-and-such, if you will...and if you don't do it, it's because you really don't want to help me." A potential reaction of anger on the client's part is implied; and if the counselor is vulnerable in the presence of this hostility, he will need all of the support he can get.

In short, much of the evaluation of this person is concerned with (1) observing the effect he has on other people, (2) the effect that other people have on him, and (3) the sharing of this information with him to assess his response. Ideally, a number of peers and authority figures with whom the alcoholic can relate for a period of time should be available while the evaluation is being conducted. We are really evaluating the alcoholic's ability to live and work with other people. Anything less does not tell us what we need to know about this person, his illness, and his potential for health.

This kind of close living and sharing between various professional persons requires considerable exposure of themselves; perhaps even revealing personal weakness, prejudices, and inadequacies that can be embarrassing for professional people. Maybe the counselor doesn't wish to tell the clinic nurse or the group therapist that the patient "conned" him out of five dollars yesterday to meet some emergency especially since the client used the money last night to get drunk! How easy is it for the psychiatrist to admit that the counselor's secretary made observations regarding the patient's behavior that were more accurate and meaningful than his own? How does the physician respond to a counselor who wants a written prognosis to place in his file when the doctor could easily defend a prognosis of "poor," "fair," or "good" for the same man on the same day?

Something new in the way of interagency cooperation is required. Agencies cannot be satisfied with mailing Xerox copies of medical reports or almost meaningless evaluations back and forth through the mail. There must be more investing of people between agencies, sharing of personnel, and reevaluation of how the counselor's time can be most effectively spent.

Any communication barrier that exists between agencies is a barrier to the adequate evaluation of services to this disability group. Perhaps more than any other kind of disabled person, he demands that those people who claim they have something to say to him should first learn to talk to one another. He refuses to risk exposure of himself, his ugliness, and his fear in the midst of helpers who will not risk as much among themselves. Much of our difficulty in evaluating and treating the alcoholic apparently stems from the difficulty we experience when we try to talk to one another.

10. *The client has difficulty just staying sober, yet sobriety is a prerequisite to any realistic and meaningful evaluation.*

    No one has learned, as yet, how to *make* an alcoholic stay sober. In fact, it seems that the harder people try to keep him away from alcohol, the more intent he becomes on asserting his independence by drinking.

    To complicate matters, it is not always the worst possible thing for him to drink. He may reach a point of crisis in his life when his alternatives for action boil down to three perceived courses: (1) he can become openly psychotic and require institutionalization, (2) he can kill himself and/or someone else, or (3) he can drink. In such a context, drinking may be seen as the only choice by which he can retain some feeling of control over himself and his circumstances. It is easy to say to an alcoholic at such a point, "You have another alternative...go to an AA meeting (or to the treatment center, counselor, psychiatrist, etc.)." But while this is an acceptable alternative to us, it may be completely out of the question to him. Many reach a point in their recovery when their feelings toward the treatment person or group are so intense that contact with these "helpers" is the least tolerable thing they can imagine...so intolerable that it doesn't even appear as a possible alternative at all. Drinking, then, becomes not just a "good" choice but the best choice available to him considering his ability to respond and the choices of which he is aware.

Also, a "slip" can help to convince an addicted person who has been sober for a relatively long time that he still has a problem with alcohol, and that there is no "cure" that will allow him to drink with impunity and without destructive consequences. All of this is by way of saying that drinking can occasionally serve a kind of therapeutic purpose for the client. At the same time, it also presents the evaluation team with the task of deciphering what the drinking episode meant and relating it to their observations by which they are determining feasibility or prognosis. It may mean he is not yet ready to try for sobriety. After drinking for a number of years, an alcoholic reaches a point at which it takes him longer to sober-up after the last drink. That is, a residual effect remains in the body and mind even after he is apparently "clear." This may constitute an intermediate brain syndrome that will have an effect on his psychomotor system and leave him rather dull in some ways... though not obviously so to others nor even to himself. But the effect is there, and it does affect his functioning. Further, it doesn't take much alcohol to prevent the intermediate level of damage from showing up. A little "sipping along" can keep such a person slightly anesthetized and confused enough to affect his scores on tests, his awareness of people and objects, and his motivation. He doesn't have to get drunk; he just keeps a slight "buzz" on and remains foggy with an intake of alcohol that at one time would have had virtually no effect on him. However, instead of clearing up in a few days, he may require a whole week or even several months of complete sobriety before he is free from the toxic effect of alcohol.

The counselor may be more interested in underlying neurosis and causative factors behind the actual drinking than he is in the drinking itself, but he should not forget that alcohol itself is one of his client's problems. This factor alone makes the disease of alcoholism unique and places an additional burden on the counselor in his efforts to evaluate the applicant.

QUESTIONS IN EVALUATION OF AN ALCOHOLIC

I. What are the GOALS being Established for the Applicant?
In the rehabilitation agency, the goals of the agency play a major role in the selection of those persons who will be assisted in attaining those goals or objectives. Gainful employment is an important objective of the agency. If an applicant cannot, realistically, be expected to attain that goal, he may be "screened out" during the evaluation process and not accepted as a client.

Rehabilitation counselors are likely to become confused in their evaluation of applicants with alcoholism if those counselors do not understand the dynamics of alcoholism in terms of potential performance. If a counselor believes that complete abstinence from alcohol for the rest of the applicant's life is the one acceptable objective (that is, if rehabilitation of the alcoholic means no more drinking ever), then he is justified in screening out most problem drinkers who apply for rehabilitation services. But, if the objective is (1) a reasonable period of sobriety, not necessarily unbroken by "slips," (2) return to suitable employment, (3) increased ability to be constructively dependent on an on-going program (the counselor, AA, clinic, etc.), and (4) increased ability to manage one's life by utilizing more acceptable coping techniques than drinking, then a much larger group of applicants would be found acceptable for rehabilitation services.

There are certain minimum expectations that any rehabilitation counselor has the right and responsibility to apply to the addicted applicant, if he is to be accepted for services. These are:

A. Sobriety.
Not unending necessarily, but marked by the kind of commitment on the part of the client that indicates that he knows the severity of his problem and the importance of fighting his addiction. If he is still kidding himself about the effect that alcohol has on his mind, body, and his relations with people, he is not ready for rehabilitation services.

B. Involvement with a continuing "support group."
Alcoholics Anonymous is the best known of such groups and the most available. Many alcoholism clinics, rehabilitation residences, mental health clinics, and religious oriented groups provide services on a continuing, unending basis so that a person may use such groups for "preventive" therapy even after the initial struggle has subsided; and it becomes easier for him not to drink. Unless an applicant indicates in some way his ability to make use of such a program, the rehabilitation counselor should proceed with caution. The counselor can refer the applicant to another kind of service, but he should avoid diluting the goals of the agency by accepting an individual who is not yet ready for the agency's services. Withholding rehabilitation services has caused some applicants to reconsider their needs and the severity of their illness and seek treatment.

C. Return to gainful employment.
The time limit placed on the attainment of this objective and the length of time a man

should be employed before his case is closed can vary and be debated.

II. What Treatment and Rehabilitation Resources, both Institutional and Personal, are Available for Use by the Counselor and the Client?

This is one of the most important and pressing questions. There are not enough treatment programs for persons with alcoholism, and the present structure of the rehabilitation counselor's role in most places is not conducive to work with these clients. Even if the counselor's role is redefined, he needs special training if he is to work successfully with this group. There is great variation within and between the states in the number and quality of treatment facilities and services available to the alcoholic. No state at present is considered to have adequate rehabilitation services, though some are making significant and encouraging progress.

Many rehabilitation counselors are beginning to work out ways of utilizing Alcoholics Anonymous, however, much experimentation will be needed before any general guidelines can be established for counselors to refer to in using AA as a resource. Several factors make this difficult: (1) the relative looseness of the organizational structure of AA, (2) its non-medical orientation, (3) the tone of confidentiality that makes communication with "outsiders" difficult at times, and (4) the highly divergent views of its many members toward working with professionals or other treatment philosophies. However, every encouragement should be given to individual counselors to work toward a productive relationship with local AA chapters. Both AA and rehabilitation agencies can benefit from such cooperation, for each has something to offer the other.

If needed services are not available, a counselor could appropriately spend his time and energies planning and developing them on a local level. Some State vocational rehabilitation agencies are taking the initiative in designing and developing alcoholic rehabilitation programs. In other States, presently existing programs are being placed, organizationally, under State VR agency control (see North Carolina Agreement in Appendix B).

In the consideration of resources we must include the rehabilitation counselor himself and his personal and professional readiness to become involved in this area. This "readiness" is not easy to define, but it seems to include the following characteristics:

A. Desire, or at least his non-resistive willingness, to work with these clients.
The alcoholic is good at picking up non-verbal rejection by others. If the counselor trys to work with him while attempting to conceal an attitude of hopelessness, anger, or disgust, he will soon find that his feelings have been communicated to his client as clearly as if he had spoken them.

B. Patience in the face of slow, uncertain, and/or erratic progress on the client's part.
Most counselors prefer to work with clients whose rehabilitation is relatively predictable. Alcoholic rehabilitation progresses in spurts, slips, and stalls; and sometimes there are long periods of time when no one knows how to describe what is happening.

C. The counselor's willingness to fail and to allow this client to fail.
This can be the hardest part. There will be times when the counselor must face the fact that there is nothing more that can be done for his client; and, as far as anyone can tell, nothing more the client can do for himself. The counselor cannot depend on a high percentage of client-success for his professional gratification.

D. Ability to examine himself and be aware of his own emotional needs and defenses, and how these can affect the counseling relationship with the client.
He should not be a person who has to be right, either with his client or with his co-workers, for he will be wrong a good percentage of the time in his work with alcoholics.

E. The counselor's ability to tolerate ambiguity.
He often will have to "fly by the seat of his pants" rather than by structured guidelines. He will be working as a team member with other professionals who don't have many answers. This can add to his anxiety, especially if these team members are representatives of professions that, traditionally, have been expected to produce pat answers.

Ideally, the counselor should begin his work with this disability group under the close supervision of a person or a team of persons who are experienced in alcoholic rehabilitation. But, often this is not possible.

Finally, regardless of how willing, patient, aware, etc., the counselor is or how ideal the therapeutic resources available to him, there is a limit to the number of clients he can effectively carry on his caseload. If he works only with this problem area, though the maximum will vary from counselor to counselor, there is reason to be concerned when the total number of cases (referred and active status) for any counselor exceeds fifty. If the counselor has a counselor aide assigned to him, and a secretary of his own, the maximum *might* be pushed to seventy-five, provided the counselor's only function is that of serving his caseload.

In conclusion, and to repeat, the feasibility of an applicant should depend in part on the degree to which treatment and rehabilitation resources are available. The resources include buildings, programs, and adequate equipment, but more important, competent people. The alcoholic has a problem with people, and people have a problem with him. People are involved in his illness; therefore, they must be involved in his rehabilitation.

EXTENDED EVALUATION

Previous sections have emphasized the problem of predicting probable outcome of rehabilitation services provided to clients with alcoholism. The intuition of a perceptive rehabilitation counselor coupled with complete and accurate information constitutes the best basis for determining when and if services should be initiated. The Extended Evaluation Provisions (PL 333, 1965) make it possible to accumulate information on those addicted clients whose situation is difficult to evaluate.

There is a valuable purpose that can be served by a counselor's placing an alcoholic applicant in Extended Evaluation, apart from the need to learn more about the applicant. If a counselor is faced only with the two alternatives of declaring the applicant ineligible for services on the basis of non-feasibility, or accepting him and being faced with the necessity of writing a realistic rehabilitation plan in a relatively short period of time, the counselor may be inclined to just close the case, non-feasible, and avoid the problem of constructing the plan with the client...especially if the counselor is uncomfortable with this alcoholic anyway. But, if he has a third alternative, that of suspending or slowing down the decision-making for a time, until he can gain some confidence in being with his prospective client, he might be more inclined to eventually accept the applicant and face the problems.

In reference to Federal Regulations regarding Extended Evaluation, the following recent revision was made regarding alcoholism: Manual Transmittal Letter #68-2 (July 26, 1967), in discussing Revised Chapter 16 of the VR Manual (Paragraph IV C of Section I), expressed the view that a person with alcoholism, "without the co-existence of mental illness or brain damage," should not be eligible for longer than 6 months extended evaluation. Future experience and research may suggest a change in this position, but the ruling seems wise at this point.

With few exceptions, rehabilitation services normally available may be authorized under Extended Evaluation. For example, the counselor may want to observe how the client responds to a period of psychiatric treatment. He might wish to have the client evaluated in a work adjustment setting or to initiate detoxification procedures at a hospital or from a physician's office before determining probable outcome.

As noted earlier, the alcoholic's performance on standardized tests may indicate a higher level of functioning than he can actually maintain over an extended period of time. The situational stresses that tend to cause episodic drinking bouts may be determined after an Extended Evaluation. Generally, the nature of the disease requires a longer sample of behavior than provided by the typical standardized psychometric measures. If a brain syndrome is indicated by preliminary screening tests, the testing should be repeated three to four weeks subsequent to the initial testing to determine current status. Guidelines for evaluation services are presented in Appendix A.

Chapter V

TREATMENT MODALITIES*

The classification of people with alcoholism is of little value unless it can be used as a basis for determining what services are likely to lead to positive results (see Chapter II of this report). Since we are concerned with a complex group of disabilities and since so little is unequivocal in this area, classification is a difficult task.

In essence, there are six major treatment approaches available to us at present. The problem is to select the best combination of these for the individual patient in his current circumstances. It is important to view these various possible treatment alternatives not only in the light of patient needs but also from the point of view of the counselor's capacities and the available resources. It is imperative that any "treatment plan" be seen as "for now" with the realization that it must be reviewed and adjusted every few weeks or months to meet the patient's changing needs. The six major approaches are:

1. Acute Detoxification

   a. Treatment of acute withdrawal symptoms.

   b. General physical and appropriate treatment of disabilities found.

   c. Complete blood count (CBC), urinalysis, a blood serologic test for syphilis (VDRL), chest X-ray, a liver function test (BSP) are usually essential.

   d. Electrocardiogram (EKG), fasting blood sugar (FBS), psychological testing, psychiatric evaluation, etc., are frequently quite useful.

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*The information in this chapter was provided by Dr. Vernelle Fox.

e. Treatment for anxiety and/or depression, as needed indefinitely.

f. Antabuse.

Acute detoxification is needed by almost all patients. The above is the minimum screening that these clients need if an adequate program is to be designed for them. Appendix H contains an outline of information designed for physicians inexperienced in the treatment of alcoholism. Those using this report should make this information available to physicians who they feel could profit from it.

Treatment for acute withdrawal symptoms frequently has to be accomplished before the medical evaluation as specified above can be completed. This can be done in a hospital, in a clinic, or in an office, depending upon circumstances. Patients may need medical attention in the form of appropriate tranquilizers and/or anti-depressants for the periods of severe anxiety or depression that can be expected for the first two or three years of sobriety.

2. Chronic Detoxification

a. All of the above plus treatment for liver damage, anemia, intermediate brain syndromes, et cetera.

b. Treatment for obesity.

c. Liver function test (BSP), every two months until stabilized.

d. Vitamins intra-muscularly (IM), two times a week for one month; one time a week for two months; one time every two weeks indefinitely.

e. Vitamins by mouth (po)

f. Iron as needed (prn)

g. Diet, et cetera.

h. Treatment of all other disorders found.

After the client has had acute detoxification and a general medical workup, it may be found that he needs chronic detoxification. This consists of continuing medical treatment and can be done from a hospital, a doctor's office, or any appropriate community resource. If he has liver involvement, he will need medication, diet, and laboratory studies every two months until it is stabilized or recovered. He will probably also need vitamin therapy twice a week for a month, once a week for two or three months, and once every two weeks indefinitely. These are the kind of specific things that the consultant physician and counselor can work out in view of patients' individual needs. This could be available anywhere if the counselor knows what to ask for and the physician knows what is expected of him. Even after the first acute detoxification, and if the patient never takes another drink, he still needs this type of long range somatic treatment. A substantial percent of the alcoholics who apply for services from rehabilitation agencies will need proper medical care. Some of our previous frustration and failure with this group have stemmed from the fact that we have bypassed this need, moving right on into some insight therapy program which the client is unable to even comprehend. We have not been gearing the program to the patient's need. It is imperative that we determine these needs at the beginning. He may have ulcers, gastritis, emphysema, etc., and, if so, should receive appropriate treatment. If we do not take care of the whole person, there is no point in going into specific alcoholism programs. If you are not going to medically restore the man in the beginning, anything else you might want to do is likely to be a waste of time.

3. Environmental Manipulation

    a. Move closer to clinic or other treatment resources and/or to environment less conducive to drinking.

    b. Contacts with: doctor, minister, boss, probation officer, rehabilitation counselor, school or training program, welfare worker, landlord, Alcoholics Anonymous sponsor, et cetera.

In general, almost all factors which would point to the need for chronic detoxification would indicate a need for environmental manipulation. The client with this much disability will usually need considerable help to break the old patterns which are so conducive to drinking. Other factors that would point to this need would include: homeless and unattached people, individuals with psychosis not severe enough to necessitate commitment; clients with moderately severe intellectual impairment and/or gross social deprivation, history of recurrent difficulties with the law, long-standing welfare assistance, gross job instability, et cetera. Usually the client presents a combination of these difficulties and when he does, it is unrealistic to expect counseling or "therapy" alone to be effective. It is essential to attempt to change his external environment in order to get lasting improvement in his capacity to function.

4. Supportive Therapy

    a. One or two individual conferences for program planning.

    b. Supportive and/or follow-up counseling.

    c. Check with medical resource regularly.

    d. AA attendance.

What findings tend to indicate the need for supportive therapy? People whose history indicates gross dependency needs, people with marked social deprivation, clients who manifest depression, marked repression, and/or considerable rigidity (these characteristics are usually obvious by history and/or interview and are also frequently observed on personality tests). The rehabilitation counselor is in a unique position to offer this kind of help, either personally or indirectly by coordinating services from other resources. He can offer the low-pressure, relatively long-term support that this type of client needs. The essential thing is to have clear expectations of clients and realistic goals for him. Difficulties in the past have stemmed from:

(1) Insecurity on the part of the counselor causing him to distrust his own ability to evaluate these needs and placing undue importance on the need of elaborate psychiatric evaluation, testing, et cetera.

(2) Lack of clear awareness of the chronicity of these difficulties and their care, which has allowed him to get caught up in the client's (or agency's) magical expectation of rapid lasting change. It is imperative for the counselor to continually remind himself that the dependent, depressed, denying, and/or deprived client can grow, mature, and learn to accept responsibility but at a very, very slow pace.

(3) To move in too rapidly, to expect very close involvement, or to demand quick results leads either to losing the client or having him deteriorate to an even less effective level of functioning. In this area, a counselor might well consider seeing a group of these clients together each week. The peer group identity thus

formed can greatly reinforce the counselor's supportive program.

There is another group of clients who lend themselves well to supportive therapy. These are individuals whose histories indicate considerable stability and strength. They may have developed a drinking problem relatively late in life or have a history of substantial periods of sobriety with or without help. As a rule, the drinking problem is precipitated by sudden gross role change because of environmental or physical change, loss of a significant person on whom they were comfortably dependent, and/or the onset of depression.

Another group of people who need support rather than insight consist of those clients who show marked somatic fixation. They "can't breathe," "are having a heart attack," "back hurts," "leg hurts," et cetera. These are not "malingerers" but are severely chronically anxious individuals who cannot conceptualize or verbalize their conflicts but can only experience them physically. It takes years, in some cases, for these people to be able to overcome their somatic fixation and begin to relate conflicts with feelings, much less with behavior. During these years, the rehabilitation counselor is in a unique position to offer the kind of support that enables the client to remain on the job while these changes slowly evolve.

5. Internal Change Therapy

   a. Orientation groups.

   b. Movies and discussion.

   c. Group therapy and/or individual interviews.

   d. Rehabilitation counseling.

   e. Social case work.

   f. Pastoral counseling.

What are some of the factors that should make the counselor think of adding internal change therapy, group or individual, provided or purchased, to the client's total program? This question is too often asked at the beginning of the "plan rather than at some intermediate stage where it could be more profitable. A big problem in the past has been the fact that we are familiar with the adult psychiatric model, and to some extent these services are available. We have tended to assume that the purchase of psychiatric evaluation and treatment would be the answer for all clients with alcoholism. This has led to considerable frustration and defeat. This treatment modality should be reserved for clients with some of the following characteristics: (1) spree drinking as opposed to plateau drinking; (2) history of previous therapy with obvious involvement and some success; (3) evidence of stability such as job, supportive relationships, home attachments, family, etc.; (4) a capacity for conceptualization and/or abstract thinking; (5) sufficient agressiveness to engage in active encounters; and (6) a history of acting our behavior and/or evidence of cyclic mood changes.

All these characteristics can be found to some degree in most clients. The real key for the counselor is the problem centering on the client's predominant situation, personality, and behavior patterns and not getting seduced by "minor themes" as they are presented. These patients are notorious chameleons; and in their fragmentation and lack of adequate identity they will present to the counselor any picture that they have seen, read, or intuitively feel might catch the counselor's attention.

6. Treatment for the Counter-Alcoholic

a. Individual interview with spouse or significant others.

b. Joint interviews.

c. Group therapy and/or individual for the counter-alcoholic.

d. Alanon.

The sixth treatment modality that may often prove to be a vital component of a successful treatment program is work with the counter-alcoholic. The counter-alcoholic is the individual or group whose sick needs are being met by the client's drinking behavior. The basic tendency is to think only of the patient's immediate family in this role. It is essential to keep an open and even suspicious eye out for the source of pressure for the client to maintain the status quo including his destructive drinking behavior. It may come from not only spouse or parent, but also from offspring, employer, employees, siblings, landlord, homosexual partner, treatment facility, law enforcement agency, church group, et cetera. These pressure groups can be amazingly devious and subtle. The hidden agenda is frequently difficult to deal with. It is sometimes possible for the experienced counselor to recognize in the beginning that this additional help will be necessary. More often this "mandate" will not present itself until after he has been working with the client for awhile. Some of the most obvious factors that need to be considered are: (1) the description of an obviously disturbed spouse to whom the client is currently quite attached; (2) patients who are in serious difficulty with drinking by age 25; (3) clients with obvious mother attachments who are approaching middle age; and (4) individuals with histories of apparently sincere but always unsuccessful attempts to get treatment in the past.

A good example of this kind of situation exists in the form of a young male client, age 25, who is basically still interested in "wheels and drinking with the boys." He also has a 19 year old wife and two children. She has become interested in being a wife and mother and having a husband with some stability. He is in difficulty with drinking along with other kinds of acting out behavior such as glue sniffing. To attempt to deal only with this young man's drinking behavior would be futile. Almost invariably, there will be a mother figure in the picture who considers her "baby boy" as having been imposed upon by having a wife and children. There will also be a father figure who does not feel that the son is mature enough to assume this responsibility and who is attempting to carry his difficulties for him. In such a situation if the entire family complex is not treated, attempts at rehabilitation have very little chance of success.

Listed in Table I are some of the factors that would tend to weigh the choice of treatment and modalities.

Table I

Conditions which suggest: Chronic Detoxification	Conditions which suggest: Environmental Manipulation
a. Age over 60	a. Homeless or
b. Plateau drinking	b. Unstable living
c. Problem 15± years	c. Psychosis
d. Mixed addictions	d. Low IQ
e. Convulsions	e. Trouble with law
f. BSP 15±	f. Welfare
g. Organicity	g. Job instability
h. Diabetes	
i. Anemia	
j. Emphysema	
k. Neuritis	
l. Chronic disabilities (arthritis, etc.)	

Conditions which suggest:
Supportive Therapy

a. All of the above
b. Gross dependency
c. Gross social deprivation
d. Severe depression
e. Marked repression and/or rigidity
f. History of long sobriety with or without other treatment
g. Somatic fixation
h. Gross and/or sudden role changes

Conditions which suggest:
Internal Change Therapy

a. Spree drinking
b. Previous therapy with some success
c. Has job and some supportive attachments
d. Has home and some supportive attachments
e. Capacity to conceptualize and/or engage in active encounters
f. History of fair stability
g. Aggressiveness
h. History of acting out behavior
i. Cyclic mood changes

Conditions which suggest:
Treatment for the Counter-Alcoholic

a. Obviously disturbed spouse
b. Client under 25 years of age
c. Mother attachment
d. Frequent failures in past

For example, the determination of the needs for chronic detoxification will be made from the findings of the medical evaluation. In addition, other factors should be considered. Some of these would be: patients over 60 years of age, clients with a history of heavy plateau drinking, those whose problem has existed for 15 years or more, patients who have mixed alcohol and drug problems, history of recurrent convulsions, demonstrable liver pathology, evidence of organic brain impairment from either psychiatric or psychological evaluation, evidence of peripheral nerve damage, diabetes and/or other metabolic disorders along with alcoholism, and other severe chronic disabilities such as arthritis, gastric ulcers, et cetera. All of these findings tell the counselor that the client is grossly depleted and will need several months (two to six) of physical restoration before much could be expected of him in terms of productive work, retraining, et cetera. During this time antabuse could be extremely valuable adjunctive therapy (see Appendix A). If this person needs chronic detoxification, the counselor should specify this clearly to the client.

All of the attempts to explain selection of clients for constellations of treatment attitudes are by necessity, generalizations which can only serve as broad suggestions for the rehabilitation counselor.

In spite of the lack of unequivocal guidelines and proven treatment approaches in this complex area, the rehabilitation counselor is in a better position than almost any other helping professional to function as a coordinator to insure the kinds of services and continuity of care that is essential for this difficult group of clients. He has the prerogative of crossing disciplinary lines, requesting specific services, and in turn utilizing and integrating these services to the ultimate benefit of the client.

Chapter VI

IDENTIFICATION AND UTILIZATION OF AVAILABLE RESOURCES

Alcoholic rehabilitation programs require a coordinated treatment approach using the knowledge and skills of a wide variety of professional and lay resources. The resources available to meet the needs of clients with alcoholism will vary greatly between and within the states. In addition to consideration of the resources available in the community and those which could be developed, the rehabilitation counselor should also think in terms of the client's going to another community for services not available locally.

The list of resources which follows is incomplete, but it may provide some ideas from which a counselor can develop an appropriate resource list for his own area. Since the function of these agencies and groups vary somewhat from one locality to another, the counselor will need to contact the agency representatives in his area and determine the services which they can provide.

I. Public Agencies and Facilities
    1. State Commission on Alcoholism
    2. Public Health Service
    3. Department of Mental Health
    4. State Hospitals
    5. Public Assistance Programs
    6. State Employment Service
    7. County Hospitals (county and city treatment facilities)
    8. Law Enforcement Agencies
    9. Community Mental Health Centers
    10. State and Local Alcoholism Programs
    11. General Hospitals
    12. Veterans Administration Services

II. Volunteer Agencies
    1. Alcoholics Anonymous, Alanon and Alateen
    2. National Council on Alcoholism and Affilitates and Mental Health Associations
    3. Council of Social Agencies
    4. Family Counseling Services

5. Churches and Related Groups
6. Professional and Business Associations
7. Residential Facilities
8. Legal Aid Societies
9. YMCA and YWCA
10. Red Cross
11. Salvation Army, Union Missions, etc.
12. Organization of Municipal Judges
13. Probation and Parole Associations
14. Service Organizations
15. Specialized Alcoholic Treatment Programs with private and community support

Rehabilitation agencies are no better able to provide total rehabilitation for all alcoholics than any other public or private agency. As a matter of fact, the very nature of State agency regulations, even though liberally interpreted, demands that they rule out all alcoholics except those whose prognosis for employment is at least fair.

Although they cannot and should not provide total services for these clients, these rehabilitation agencies should become an active force in the treatment of alcoholism. They must be ready to evaluate legitimate referrals from any source and lend full assistance within the scope of their capabilities.

In any cooperative approach to the problems presented by an alcoholic, some individual or agency must be in a position of coordinating and, in certain instances, developing the resources to meet these needs. Often this role will fall to the rehabilitation counselor.

Effective services are not provided by agencies but by individuals working within the framework of agency policy and procedure. However, even in an area where there is a complete lack of formal organizations usually associated with treatment or rehabilitation of the alcoholic, the possibility of enlisting the support of interested individuals in the community should not be overlooked. Such persons, as a understanding minister, school teacher, social worker, police official, or businessman, may be able to provide the day to day support that is necessary in successfully rehabilitating the client with alcoholism. The rehabilitation counselor contemplating working with this type client, particularly in a rural area, should carefully seek out these understanding community leaders. He should make himself available to them to provide the kind of support and encouragement they will need as they attempt to perform this difficult task.

The rehabilitation counselor should remember that no perfect model for providing rehabilitation services to the alcoholic exists. The rehabilitation program must be planned for the individual to meet the needs which are identified at the time. The plan must remain flexible so that needs may be met as they emerge. The two following case histories are illustrative of these points.

Case Histories

1. The first case history, Mrs. A , is a 38 year old, white, married mother of four children, who was referred to the rehabilitation counselor from a rural community of approximately 700 population. The referral was made by the county judge and was made on the basis of alcoholism. Mrs. A's husband is a 42 year old heavy equipment operator who had provided well for the family until four years before referral when a severe heart attach resulted in total disability. During the initial stages of her husband's illness, Mrs. A drank to relax and relieve tensions. The after-effects of the heart attack were so severe that Mr. A was unable to return to work after his release from the hospital, and it was up to Mrs. A to obtain employment as a waitress in order to keep the family together. Mr. A could supervise the children, ages 4, 6, 11, and 13, but could not do heavy household chores; so it was up to Mrs. A to do these after work.

   The reversal of the roles of the husband and wife caused conflicts and frustrations for both individuals; soon constant nagging and fighting began. Mrs. A began drinking more often during non-working hours. Over a period of two or so years, Mrs. A began drinking on the job and soon was unable to get employment because of her drinking. After being picked up for public drunkenness and jailed on several occasions, the county judge referred Mrs. A to a rehabilitation counselor.

Arrangements for a medical examination by a local physician were made and a tentative diagnosis of alcoholism was made with recommendation for more complete evaluation at a clinic some 120 miles away. Refusal on the part of Mrs. A to admit that she had alcoholism and guilt feelings about leaving an invalid husband and minor children made it unfeasible to carry out these recommendations.

The rehabilitation counselor realized that the successful rehabilitation of Mrs. A and her family was a community problem. He began by providing supportive counseling for the family while soliciting help from the community. Arrangements were made for Mrs. A to see the local physician twice a week for medical treatment of her alcoholism and additional medical disabilities. The physician placed her on antibuse and encouraged her to use it. A female Alcoholics Anonymous member and acquaintance of Mrs. A was asked to make a social call on Mrs. A in order to give her someone to relate to and be available for specific AA work if Mrs. A became willing to accept it.

While providing supportive counseling for the family, the rehabilitation counselor made arrangements for evaluation of Mr. A with the idea of providing training and employment in his home that would be of a masculine nature and allow him to provide general supervision of the children. During the evaluation the counselor referred Mr. A to the Social Security Disability Benefits Program. The local representative of the State employment commission was asked to help with a possible employment solution.

The local school authorities, including the principal and county school counselor, were contacted to help with the adjustment problem of the 13 year old who became incorrigible. A local minister was contacted and arrangements were made for Mrs. A's children to be included in more church activities which was not only good for the children but also helped relieve the father of some of the baby sitting chores.

Arrangements were made with local Welfare representative for the family to receive Aid to Families with Dependent Children (AFDC) payments while applying for disability benefits from Social Security. After Social Security benefits were begun, Mr. A began training for a small business enterprise in his home. Mrs. A continued her treatment and was able to return to work as a waitress. Over a period of about 18 months, Mr. A was able to set up his home business and Mrs. A was able to gradually reduce her outside work until she could spend full-time at home caring for the children while Mr. A carried on his business. Planning and coordinating conferences were held with all individuals working with this family, and eventually the family was rehabilitated as a result of interagency and community effort.

2. The second case history is a 56 year old, white, married father of eight children (four at home) who was referred to the rehabilitation counselor by the social worker at the State Alcoholism Clinic. The client wrote to the counselor before leaving the clinic asking the counselor to have a job ready for him when he returned home. The counselor, of course, knew very little of the background of this client and his abilities and made no attempt to find employment until he was able to meet the client and assess the magnitude of his problem and evaluate his aptitudes.

The counselor was fortunate in working with this particular case because a local alcoholism clinic had been set up by the Public Health Department. The client became one of the first patients to be treated at this out-patient facility. Part of the services of this clinic included the assistance of a psychiatrist, volunteer minister-counselors, public health nurses, a public health physician, Director of the local Department of Family and Children Services, and a rehabilitation counselor. The client had considerable experience in group therapy at the State Alcoholism Clinic and, therefore, adjusted well to the local clinic setting and was a faithful member of his treatment group.

It soom became evident that the primary source of the client's problems and his reasons for drinking were family problems that centered around an unhappy wife.

The psychiatrist advised postponing training or job placement for this client until he became more stable. During this waiting period, the client's family received Aid to Dependent Children. They also received surplus foods distributed by the Department of Family and Children Services.

Eventually the staff at the clinic agreed that the time had come when this client should participate in a training program. The staff also advised the client to seek another place to live to remove him from the neighborhood where many of his old drinking group lived. A situation developed that would enable the client to train with a friend of his who was not a drinker. He also owned a house with some acreage outside the city that he would allow the client to use rent free. The client and his family would also have the possibility of a garden and space to keep chickens, a pig, and a calf or two if they so desired. A problem developed at the time of moving. This client's teenage daughter refused to move with the family. An older, married, and childless sister had encouraged her younger sister to move in with her. This created a crisis in the client's rehabilitation process. However, a social worker at the Department of Family and Children Services who knew the client's married daughter was able to talk to her and encourage her to let her sister remain with the family. The family moved on schedule.

The counselor contacted the local school and made arrangements for the client's teenage daughter to become a member of the 4-H Club, and she had as a project a registered Black Angus purchased by a local civic club.

During the training period the client's wife became upset because the client was not earning as much money as she thought he would, and the client went on a drunk. His wife called the Public Health Nurse and also called the police to have him arrested. The Nurse contacted the police and had them not formally arrest the client but to hold him until he had sobered up as he had violated no law and was simply drunk in an outhouse at the farm.

One couldn't wish for a better spirit of cooperation than existed which involved the (1) psychiatrist of the State clinic, (2) psychologist, (3) nurses of the local Public Health Department, (4) Director and social workers of the Department of Family and Children Services, (5) the minister-counselors, (6) the employer-trainer, (7) rehabilitation counselor, and (8) police department in attempting to help this client help himself.

This case was closed successfully rehabilitated.

CONCLUSIONS

Rehabilitation of alcoholics is one of the most difficult charges facing counselors today. This difficulty should not, however, hide the fact that this is one of the most worthwhile areas in which the counselor can become involved and one in which he has an unique and effective service to offer. Many alcoholics who have refrained from drinking have been found to be extremely creative and productive citizens.

There are areas of concern which should be recognized by the counselor who is beginning to work with these clients. One of these is the resistance from the community. Rehabilitation of the alcoholic requires cooperative efforts by large numbers of organizations and individuals. This type of close interpersonal cooperation necessitates a system in which threat to the participating professionals may become a major issue. The counselor would be well advised to realize the potential dangers inherent in this situation and be prepared to deal with them.

Rehabilitation counselors should recognize that the provision of services to this group is time-consuming. The pressures for a quick closure are contrary to working with the alcoholic client. Many more of the individuals' needs than just that for sobriety must be met. The sober alcoholic is still an alcoholic, and the rehabilitation process is not complete but only started when the client has ceased drinking. To consider the case closed when the client has been sober for a specified time and is gainfully employed is a self-defeating form of economy. Premature closure will, in most instances, only insure the return of the person to a client status.

The counselor must also realize that rehabilitation of the alcoholic client will not always progress smoothly toward the desired objective. Part of the process of recovery may well be the testing of new thought patterns relating to his inability to drink socially. The counselor and others must be able to reinforce these and use them in the rehabilitation process.

All considerations of feasibility have concluded that there is no way to establish a realistic set of guidelines for determining the feasibility of alcoholics for rehabilitation services that will apply to all clients, in all States, for use by all counselors. To attempt to do so would be to restrict and discourage the very thing that is needed most critically at this point in history: creative experimentation by all personnel. We do not need a carefully worded "manual" at this point...we need to try to work with as many alcoholics as possible, as soon as possible, and in as many ways as possible, so that at some future date another study committee will have more reliable data to evaluate than is available today. We need to commit ourselves to the task of learning by doing, by succeeding as well as failing.

Chapter VII

IMPLEMENTATION OF PROGRAMS FOR REHABILITATION OF THE ALCOHOLIC

During the last decade, a number of Social and Rehabilitation Service supported projects have demonstrated the value of rehabilitation concepts and services in the rehabilitation of alcoholics. These projects have provided evidence that the costs for rehabilitating these clients is considerably cheaper and the long-range results more rewarding than the "revolving door" method of continued arrests and incarcerations (see Appendix A for a description of the Emory University, Atlanta, rehabilitation project for the chronic court offender alcoholic).

A recent survey made of State program efforts directed toward rehabilitating this group revealed the following program patterns:

1. The alcoholic is accepted as a referral from the general population and is evaluated for rehabilitation services the same as other disability groups.

2. Most alcoholics are received as referrals from State mental hospitals after treatment has been provided, and the referral to rehabilitation counselors is on the same basis as any other referral from the mentally ill population served by the hospital.

3. Where the Public Health or Mental Hygiene Clinics have established special alcoholism treatment units, rehabilitation staff has been assigned to serve referrals from the clinic.

4. Specially trained staff has been employed to coordinate rehabilitation services for these clients and provide statewide followup on cases that are served through special treatment centers. State agencies should develop a pre-service and in-service training program for all staff members

working with the alcoholic rehabilitation. There are many formal training programs throughout the country available at little or no cost. A list of these training courses is included in Appendix F. Also, there is a list of training films in Appendix G.

These program patterns have provided services to increasing numbers of alcoholics and have given us valuable information in regard to their unique needs. However, they have not proven as effective either quantitatively or qualitatively as needed.

The complex problems presented by the alcoholic make it necessary to go beyond traditional concepts in rehabilitation. Discrete services, rendered independent of each other, seem to have a more harmful effect on this group than most other populations of rehabilitation clients. A coordination of all needed services in an intensified comprehensive program for each client appears to be the only really effective method.

COOPERATIVE PROGRAM APPROACHES

Practically every state has designated an agency responsible for the treatment of alcoholics. Generally, State mental hospitals or community mental health centers have served as treatment centers for alcoholics. Now State rehabilitation agencies have responsibility for serving this group where the disease constitutes a handicap to gainful employment of the individual.

Through cooperative agreements involving all State agencies with interest in serving alcoholics, the available resources of each such agency can be pooled instead of being fragmented as often exists at present. The North Carolina Department of Mental Health, Division of Alcoholism, and the North Carolina Division of Vocational Rehabilitation have an agreement to work together cooperatively in planning, developing, and implementing a statewide goal-oriented program of rehabilitation services for this group (see Appendix B for a copy of this agreement).

Cooperative programs may be institutionally based or may be designed as a specific local service operation serving alcoholics on an out-patient basis.

Cooperative institutionally based programs are usually comprehensive in nature and have their own physical plant especially designed to house a wide range of professional services. Such a special facility located on the grounds of a State institution (such as a mental hospital) actually comprises a comprehensive rehabilitation facility as defined in the Federal Act and, thus, would be eligible for special consideration in financing.

At the local level, the rehabilitation program might best be located in a community mental health center or an alcoholism clinic having its own staff, facilities, and budget. Rehabilitation services would be in addition to the other on-going services of the sponsor. The rehabilitation services provided in a community cooperative program may range from limited to very comprehensive. Some examples follow:

1. The State agency may assign a counselor to a specific local mental health or alcoholism clinic to provide counseling, planning, and placement functions for eligible alcoholics who may concurrently be receiving treatment from the local clinic. The counselor may arrange for vocational evaluation, locate community training resources, find jobs, provide individual or group counseling in regard to work adjustment, et cetera. He may arrange for additional rehabilitation services as needed by the individual such as psychological or medical examinations, physical restoration services, training services, training materials, and placement equipment using agency funds for this purpose.

2. A modest program at the community level may consist of one or more counselors, a shop or special area for work evaluation, a program of personal adjustment, training and work conditioning in relation to job readiness, and special job training all carried out on the premises of the clinic.

3. A more ambitious community program would include the services mentioned above plus full-time psychological services, social services, and special services such as specific job training programs carried out in the unit and through on-the-job training in the community. This approach would be multi-disciplinary rehabilitation at the community level for intensive work with these clients.

COOPERATIVE PROGRAM CONCEPTS

Each cooperating agency should provide those services which lie within their area of responsibility with funds made available for such purposes. For instance, Departments of Mental Health, Commissions on Alcoholism, or other agencies have traditionally responded to the needs of the alcoholic for detoxification, psychiatric treatment, medical care, and social services. However, cooperative programs will necessitate modifications in institutional and local programs in staffing patterns. Even with these advances, it is recognized that the alcoholic still faces barriers in obtaining a satisfactory adjustment in the community, including a suitable job. This leads to a natural union of the mental health agency and the rehabilitation agency in the provision of services in this area of mutual interest.

A cooperative program for the alcoholic is simply a formalization of the commitments of two or more agencies to organize, improve, expand, and focus in the most meaningful way their respective services on the needs of the client. These needs encompass intellectual and cultural development, personal adjustment counseling, job training, and job placement. It may include such additional services as family case work, health programs (particularly health maintenance), and special recreational programs including use of leisure time.

To achieve these objectives, the vocational rehabilitation commitment to a cooperative program, whether established in cooperation with an alcoholism treatment program at a large institution or in a smaller local program, might contribute the following services:

1. Rehabilitation Evaluation - Consists of use of medical records and supplementary facts secured by rehabilitation counselor, i.e., test results, medical examinations, and data from interviews and observations, to determine eligibility for rehabilitation potential (refer to Chapter IV for additional information).

2. Counseling and Planning - To be carried out cooperatively with client and family, to ascertain assets, problems, and goals of client, and to formulate a practical plan of services designed to prepare the client for employment at his highest level of potential.

3. Extended Evaluation - A formalized plan of study and evaluation over an extended period of time as required to get a more valid measure of rehabilitation potential. Trial training, additional professional evaluation, trial treatment, and work tryouts are principal modalities of extended evaluation. These services may be provided within the units or by use of facilities in the community such as workshops and rehabilitation centers.

4. Work Evaluation, Work Conditioning, and Prevocational Training - Using actual or simulated work tasks in special shops, in sheltered workshops, or in technical schools or community work situations, clients with needs for such services may be given periods of training or work experience as a means of creating readiness for specific training or work opportunities.

5. Job Training - Under an individual plan of rehabilitation, such training may be arranged at a training site in the community, full time or part time, and in either formal vocational classes or on-the-job training. Such training provided under the auspices of the rehabilitation agency should not be in competition with vocational programs already available to such clients from the agencies.

6. Job Placement and Follow-up - For rehabilitation clients these services may include job development activities and counseling with employee and employer to the point that a placement is judged to be satisfactory. They should be rendered by the professional staff on the rehabilitation agency in close coordination with cooperating agencies.

7. Restoration Services* - Restoration required to correct, materially reduce, or stabilize a handicapped condition which adversely affects employability may be purchased by the rehabilitation agency. These services might include surgery and medical services, treatment including individual and group therapy, prostheses, hospitalization, physical therapy, occupational therapy, speech therapy, et cetera.

8. Transportation - These services are limited to those required for completion of diagnosis, extended evaluation, training, or other services under an individual rehabilitation plan.

9. Maintenance* - This includes funds for living expenses necessary to complete a rehabilitation plan when the client is unable to secure such at home or otherwise without cost to the State Rehabilitation Agency.

10. Psychological Services - These services may be supplied by a staff psychologist or may be purchased on a per case basis. There should be no duplication of psychological services already available to clients from State or local alcoholism centers.

11. Social Services - The program may include social casework services rendered to clients and their families to aid in the solution of social problems affecting progress in rehabilitation. These services generally would be provided by a staff social worker.

* Based on establishment of economic need if required by State Plan.

The primary condition for the provision of these rehabilitation services is (1) the determination that the client meets the basic eligibility requirements for rehabilitation, (2) that such services are formally specified as representing client's needs after preliminary evaluation, and (3) they have been included in a formal rehabilitation plan.

PATTERNS FOR FINANCING COOPERATIVE SERVICE PROGRAMS

In relation to cooperative programs, two types of expenditures are presented. The first are expenditures for psychiatric and acute medical care for the alcoholic along with other traditional services provided by alcoholism commissions, mental health agencies, or other appropriate agencies. The second are expenditures for rehabilitation services for these clients made by the State rehabilitation agencies. Each operates under its own set of laws, regulations, and policies and must make separate accounting to appropriate authorities for such expenditures.

Rehabilitation funds come generally from two sources:

1. Allotments from the Federal government as provided in the Federal Vocational Rehabilitation Act through the Rehabilitation Services Administration.

2. Appropriations by the State legislature for vocational rehabilitation purposes.

In addition to these primary sources, funds may be secured through special allotment by a governor through allotments from other State agencies when approved by appropriating State fiscal bodies; allotments from local governing bodies such as (1) city councils, (2) county officials, or (3) local alcoholism commissions; or by cash contributions from (1) private agencies, (2) individuals, (3) corporations, (4) foundations, or (5) other acceptable donors. Generally, all funds received by the State agency from State, local, or private sources may be used for matching Federal funds at the approved matching ratio. The combined State and Federal funds may then be used to defray the costs of rehabilitation services and for administration as defined by law and regulations. Matching requirements for rehabilitation Federal funds cannot be satisfied by the use of other Federal funds or by State funds which are already being used to match other Federal funds. Also, Federal rehabilitation funds cannot be used to duplicate existing resources which are adequate or for the provision of services which are legally and traditionally the responsibility of another State agency.

To meet Federal requirements for Federal participation in such jointly financed programs, the following principles must be observed:

1. Selection and retention of personnel in the rehabilitation aspects of the cooperative project are subject to the approval of the rehabilitation agency.

2. In all significant aspects of their rehabilitation work, the personnel shall be subject to the supervision of the State rehabilitation agency.

3. The project activities may be considered part of the rehabilitation program only to the extent that rehabilitation services are furnished to rehabilitation clients (or with respect to diagnostic services, potential clients) in accordance with the State Plan.

4. All expenditures to be classified as "vocational rehabilitation expenditures" including both State and Federal portions must be made under the control and at the discretion of the State rehabilitation agency. This means that the State agency must approve the expenditure and be the final authority in the state for determining its necessity and its propriety.

ADMINISTRATION OF COOPERATIVE UNITS

In cooperative facility or center programs, the basic principle may be stated simply - the vocational rehabilitation agency administers the rehabilitation services program, having final decision as to its contents, operating procedures, staffing, eligibility of clients, termination of services, and application of funds. The alcoholism commission, mental health agency, or appropriate agency has similar authority in relation to all alcoholism treatment services being provided to clients concurrently engaged in receiving rehabilitation services. However, by agreement, close cooperation and coordination of services may be achieved through joint planning, professional cooperation, and teamwork. Rehabilitation unit personnel working in an alcoholism center setting should observe the rules, policies, and procedures of the host center in regard to client contacts, scheduling of services, and interaction with cooperating center personnel.

Considerable flexibility exists, also, in the method of disbursing funds. The rule of convenience applies here. For example, vocational instructors employed in the rehabilitation unit may be paid by the cooperating center using funds provided by the rehabilitation agency; or, they may be paid employees of the rehabilitation agency.

A State agency may, if its State plan so provides, operate a comprehensive Rehabilitation Center for Alcoholics, providing all the necessary services including evaluation and treatment. For example, in South Carolina the State Rehabilitation Center for Alcoholics is operated as a facility of the South Carolina Vocational Rehabilitation Department.

It is strongly recommended that a written agreement be executed by the heads of the cooperating agencies covering in detail the statement of goals, policies, procedures, organization, financing, program content, and provisions for the agreement to be updated at least annually (see Appendix B).

LOOKING TOWARD THE FUTURE*

Given the scope of the problem of alcoholism in its human and economic context, what should be our stand as protagonists for programs and services needed to restore alcoholics to useful and productive lives?

In an attempt to answer this question, I would like to offer some general observations and recommendations and speak of the future role of the Department of Health, Education, and Welfare and RSA as I view it.

First - We must continue to meet, talk, and write about the magnitude of the problem and responses that should (or must) be taken by public and private agencies, including government legislative bodies, to mount the kind of rehabilitation programs for the alcoholic that are necessary - that would be proportionate to and competitive with the demands of today - at this point in time and in history. We must keep the dialogue going - the pressure on.

Second - We must be alert to and capitalize on opportunities that present themselves for developing programs designed specifically for treating alcoholism. This is essential if we are to make services more competitive and establish a baseline for future measurements of program results.

Third - While special program emphasis is desirable at this time, it is my judgment that we would be shortsighted if we did not promote services for the alcoholic within the service programs already constituted and in operation. Alcoholism is found in all walks of life, male and female, young and old, and most ethnic groups.

*From speech presented by W. A. Crunk, Associate Regional Commissioner for Rehabilitation Services, Social and Rehabilitation Service, DHEW, Charlottesville Regional Office, to the 1968 Institute on Rehabilitation Services, May 22, 1968.

Thus, concerted services, leading to social, medical, and vocational rehabilitation for the alcoholic, must eventually become as readily available as they are for the physically disabled. While special treatment resources will always be required, many available services through our old line social, vocational, and health agencies are systematically denied by policy or professional attitude to persons suffering from alcoholism. These barriers to services must be broken down.

From the RSA view, I think that rehabilitation of the alcoholic merits both a regional and national priority. The extension of services to the mentally ill and retarded is an example worthy of emulation. The successful extension of services to the mentally ill and mentally retarded I believe can be attributed to two important factors:

1. The mentally ill and retarded are easily identified and reached. They are found as "captive" population in our institutions, schools, et cetera.

2. Powerful lay and professional groups - associations for the mentally retarded and mentally ill - have been active in promoting the development of services for these disability groups.

Both of these influencing factors have generally been lacking in respect to developing services for the alcoholics.

The principal failure in rehabilitating the alcoholic appears to be the inability of service agencies (Federal and State) to expand services to neglected groups or areas of unmet need without external prodding. Fortunately, rehabilitation agencies (and this is to their everlasting credit) have been the pleasant exception to this "business as usual" mode of operation. Yet, rehabilitation as one of the smaller public service agencies has been relatively unsuccessful in serving large numbers of the disabled. But we have demonstrated that severely disadvantaged, disabled people can be rehabilitated; and therefore, we are given an ever increasing role of leadership and responsibility in this area. At the Federal Social Rehabilitation Services level, the rehabilitation philosophy and concept is being promoted at all operational levels in an effort to redirect and make more visible and accessible to handicapped people the services each agency has to offer individually and in concert with associate agencies.

Of equal significance is the redirection of services to the poor among our population, the 40 million of our citizens who are subsisting at the poverty or near poverty level. We have only to look around us to see that the poor people are "getting in step" to demand improved housing, education, medical, and health services. We have never been engaged in a social revolution of such magnitude and intensity. Many of our rehabilitation services heretofore have just not been available to them. You might say, with full justification, that such services were not available to those in better economic circumstances. However, the impact of denial of services to the poor has been greater. We have evidence that poverty begets more poverty and creates an environment of frustration and hostility due to the hopelessness of the situation in which the poor people exist. I feel that the spirit of the times demands that concerted, coordinated efforts be made to move the disadvantaged to an independent contributory role in the community. Of primary importance in this transition is a job for those who can work.

The significance of this effort to redirect resources, including staff, facilities, and funding, should not be missed. What is visualized here is taking service programs - outreach services - to where these people reside.

Multi-agency cooperative endeavors, common programs, and service goals will be established. Thus, a disabled person, such as an alcoholic who presents himself for service or is otherwise located and referred, will have an opportunity for services which have heretofore been lacking.

To illustrate, I would like to share some of the agreements that are being reached between some State rehabilitation agencies and Public Welfare agencies. Significant to these agreements is the fact that in each case the meeting between the two agencies was convened by the governor. The specific target group in AFDC (Aid to Families with Dependent

Children) are parents and disabled family members which includes, I am confident, a sizable number of our 5 million alcoholics. Action items in these agreements are:

1. Establishment of production goals to insure agency expectation and performance in the rehabilitation of public assistance applicants and recipients.

2. Development of a classification instrument which would insure automatic referral by welfare and automatic acceptance by vocational rehabilitation.

3. Development of corollary referral standards (to automate referral procedure) which would yield adequate social, medical, and vocational information to insure automatic acceptance by vocational rehabilitation.

    a. Development of a common medical examination form (or adequate medical abstract if prior medical information is available before referral to vocational rehabilitation).

    b. Provision of adequate identifying information including family, social, and work information or histories.

4. Assurance that physical restoration, except as mutually agreed, will be provided in the amount and extent necessary through the medical assistance programs rather than through vocational rehabilitation. (Applies to Title XIX states only.)

5. Assurance that a single social and rehabilitation plan is developed on all persons accepted in the concerted services program. (Requires joint planning and commitment by VR and welfare workers.)

6. Employment or designation of a person on each State agency staff to provide leadership in carrying out objectives of the program.

7. Assurance that sufficient attention would be given to the training of joint service personnel to insure the success of the expanded VR-Welfare program.

8. Acceptance of a specific date as the date for implementation of the cooperative program including

   a. Development of a program proposal

   b. Execution of a revised agreement in the "sense of a contract"

This represents a type of commitment we have never had between the two agencies before and, hopefully, will provide a more flexible agency approach to seeking out and meeting the needs of our alcoholics and other seriously disabled groups.

In conclusion, I would leave you with these thoughts as to how I view government's evolving stance toward agency performance in respect to the provision of social services and the expectations to be derived therefrom:

1. Government no longer is activated by a social philosophy that merely forbids various practices or deals charitably with the unfortunate; but rather it is motivated to reallocate resources through political actions to produce social justice, adequate education, housing, rehabilitation, and medical care.

2. Increasingly, more questions are being asked regarding public funds being used for public purposes. Questioners are Congressmen, members of the executive staff at Federal and State levels, hard-fisted budget persons, and consumers of services. These people, as well as we, are looking for the relative payoffs from different kinds of public investments.

3. Congress and the President, governors, and the general public want programs now that are tuned to the problems of our society and to the need for developing solutions to those problems.

4. Social service programs such as ours must reflect the willingness and capability to deal with these problems. This will require as a minimum the sacrificing of professionalisms and adjustments in existing roles of professionals to the end that we create human resources personnel who can achieve overall planning, program linkage, and expedited and simplified procedures in achieving social objectives.

In these changing times, we have our greatest opportunity to focus attention on the needs of the alcoholic. This is the era for concerted service programs, program decentralizations, new approaches to planning, staff deployment, and cooperative funding.

Appendix A

Appendix A

EMORY UNIVERSITY PROJECT FOR THE EXPANSION OF VOCATIONAL REHABILITATION SERVICES TO THE CHRONIC DRUNK COURT OFFENDER ALCOHOLIC

Project Plan

Introduction

This service project will directly expand and provide a full range of vocational rehabilitation services now available in Georgia to include a large number of people, namely, the chronic drunk court offender alcoholic, who heretofore have been served in a very limited number by the one counselor assigned to the Emory University Alcohol Project by the State Division of Vocational Rehabilitation.

There are approximately 12,000 individuals in Atlanta, Georgia, classified as alcoholic drunk court offenders. Of these 12,000 individuals we estimate quite conservatively that approximately 4,000 are vocationally rehabilitatable. In time, the proposed project staff will have contact with nearly all of these 12,000 individuals at the city court and City Prison Farm. In these contacts the alcoholics will be informed of the rehabilitation project's existence and availability to them. They will be encouraged to apply for the services from the project. It is estimated that an average of ten clients will apply each day, or approximately 2,500 will be screened in a step-wise manner in a year's time. Of those evaluated approximately 600 yearly will be accepted for continuation of the rehabilitation process. This will be explained in greater detail under methodology.

The specific objectives of this project will be to quickly ascertain which of the applicants for services have the greatest potential to return to and remain on a job commensurate with their abilities based on their physical, mental, social, and vocational conditions. After once ascertaining who these people are, methods learned over the past four years by the Emory University

School of Medicine, Department of Psychiatry and Vocational Rehabilitation, will be applied to place them on a job, but, more important, to keep them employed. The treatment of their alcoholism, which involves vocational, physical, psychological, and social readjustments, will be carried on at the same time. This combination of placement on a job, continuation of support from vocational counselors and social workers, and treatment of the disease alcoholism all going on at the same time is an integral and unique aspect of the proposed project. This total process from initial evaluation to closure of the case will take a variable amount of time. Some individuals will require only a few months while others will require longer periods of time which probably should not exceed two years. It is important to realize that the very nature of this illness will necessitate a great deal of flexibility in opening, closing, and reopening cases to meet the primary objective of maintaining the individual's periods of productivity. Because the bulk of the rehabilitating process will be done after the client has returned to work, closure of a case should not follow traditional vocational rehabilitation standards but should be tailored to the individual. Also, because relapses are common, i.e., drinking resumed, in the alcoholic, reopening of a case can easily be done without the necessity of repeating many of the previous evaluation procedures.

This project to expand vocational rehabilitation services is justified by many facts which are commonly known. First, clients with alcoholism, a recognized disease, have only recently been accepted in limited numbers for vocational rehabilitation services in Georgia. The chronic drunk court offender had not been served by the State vocational rehabilitation agency, prior to the advent of the Emory demonstration project, because this group has notoriously been refractory to change by previously known methods of rehabilitation.

The most important and unique feature of the proposed method of treating the chronic drunk court offender alcoholic is based on the recognition that these individuals are totally dependent upon others to take care of them. Knowing and accepting this makes the task of rehabilitation less difficult and less uncertain.

The proposed project will use a multi-disciplinary approach to rehabilitate the drunk court offender alcoholic. Represented on the staff will be vocational rehabilitation counselors, social workers, a clinical chaplain, psychologists, physicians, and psychiatrists. The main emphasis in rehabilitation will be on "reaching out" for the clients rather than the traditional waiting for the client to request services. This reaching out is necessary because of the passive, dependent nature of the alcoholic. Once he is involved in the rehabilitation process he must be continuously supported until his total dependency can be changed so that he is sufficiently independent to function in society and to maintain employment.

Methodology

1. Facilities

A. Major facilities

Headquarters for the project consists of 9,400 square feet of office space. This will house the majority of the staff and will be the center where the most extensive screening of clients will take place, and the majority of the treatment and rehabilitation service will be carried out here.

In addition, 1,600 square feet of space will be used at Grady Memorial Hospital, this space serving as the clinical facility of the project where clients' physical health will be evaluated and treated. Also, the second phase of the screening process (which will be described later) for client selection will be carried out here. The location in Grady Memorial Hospital will facilitate obtaining service from other medical clinics when needed. Grady Hospital is the community's charity hospital having a bed capacity of 789 and a full range of out-patient services. It is the principal teaching facility of the Emory University School of Medicine.

The project headquarters and Grady Hospital are within short walking distance of each other. They are both similarly close to the city municipal court from which many of the project's clients will be recruited. The close physical proximity of these facilities will enhance the coordination, activities, and services of the project.

B. Cooperating facilities

(1) Atlanta's Municipal Court

An average of 100 cases daily are tried in the municipal court on a charge of public intoxication. The handling of these cases is such that it will be possible for the project staff to carry out a very brief and cursory examination of those appearing each day in the court.

(2) City Prison Farm

This is the city's penal facility which has a daily census of approximately 700 with over 90% of these individuals being incarcerated for public intoxication. The majority of these individuals are chronic drunk court offenders. About one-half of the clients for the rehabilitation project will be recruited from the City Prison Farm. Project teams, consisting of Vocational Rehabilitation counselors and social workers, will make bi-weekly visits to the Prison Farm, informing the inmates about the rehabilitation service and carrying out the first phase of the screening process in selecting clients for further screening.

(3) Atlanta Employment Evaluation and Service Center

This is a facility sponsored by Vocational Rehabilitation and Economic Opportunity

Atlanta to evaluate hard core unemployed and then refer them to appropriate agencies for assistance. This new facility is seen as a major resource for the project. It is anticipated that some of our clients will be referred from this agency.

(4) St. Jude's House

This is a church-supported half-way house for chronic drunk court offender alcoholics. It has a capacity of 40 residents. Referrals from the rehabilitation project who need housing will live here for variable periods of time on a rent basis paid by the individual.

(5) Salvation Army and Atlanta Union Mission

Temporary short term or long term housing, when needed by a client, will be provided by these agencies. The project will assist these agencies in developing a therapeutic environment for the clients of the project who will be using their housing facilities.

(6) Other community facilities

Other community facilities which will be utilized at times are the medical and psychiatric clinics at Grady Memorial Hospital, short term intensive inpatient psychiatric ward at Grady Memorial Hospital, State psychiatric hospitals and alcohol treatment facility, Fulton County Family and Children Services, State Department of Labor, and the EOA Legal Assistance Program. We should like to emphasize that this project will be a comprehensive community approach to the problem of the chronic alcoholic who is arrested over and over again for public intoxication. All related services in the community have already been mobilized to assist in the total implementation of this project.

2. Procedures

The aim of the methods employed is to select those clients who, in the judgment of the project's staff, have the best potential for rehabilitation. The selection of clients is to be done by means of a step-wise screening and evaluation. Once an individual has been accepted for rehabilitation service the major objective is to get the individual employed and maintain his employment primarily through efforts to perpetuate his sobriety.

A. Client source and selection

Clients for the rehabilitation project will be obtained primarily from the municipal court and the City Prison Farm. Also, some cases will be referred to the project from the Atlanta Employment Evaluation and Service Center, the Fulton County Court system, other social and health agencies, and occasionally by private physicians.

The initial contacts with the prospective clients at the court and City Prison Farm will be made by teams composed of a vocational rehabilitation counselor and a social worker. By this method the rehabilitation project will have contact with the majority of the 12,000 chronic drunk court offenders, such that they will be informed of the services available. From this population 50 individuals will be selected each week for the second phase of the screening process and brought to the clinical facility at Grady Hospital for the second phase of screening.

The second phase of the screening process will consist of a brief interview with the vocational rehabilitation counselor to obtain an impression of the individual's work potential, a psychiatric interview to determine if there are gross disturbances in mental functioning, a social worker interview to determine the individual's current environmental status and immediate needs such as housing, and a brief medical evaluation primarily to determine if the individual has any severe physical disability and if he can be started on Antabuse, a drug which prohibits drinking immediately.

Approximately 2,500 individuals will go through this second phase of screening and from the 50 subjects seen weekly the 25 most promising will be selected on the basis of a brief staffing to undergo a more extensive evaluation. In the second phase, the individual will be placed on Antabuse and housing arranged, if needed, at the Salvation Army or Union Mission.

The 25 individuals selected weekly for the third phase of the screening process will be seen for this phase of the evaluation within several days of the initial contact with the subject. A total of approximately 1,250 individuals will be evaluated in this third phase of the screening process. It will consist of obtaining a complete work history by the vocational rehabilitation counselors, with a determination of special job experience and training. Also, information pertaining to the level of education will be obtained. Subjects will be given the Beta IQ test, test for brain damage, and the Alcadd test for alcoholism. A physical examination will be made by the staff's internist to determine what factors tend to perpetuate the subject's drinking. A clinical psychiatric interview by the staff's psychiatrist will be made to evaluate the subject's current level of mental functioning, his degree of psychopathology and to estimate the subject's amenability to the treatment and rehabilitation process.

Following this third phase of the screening and evaluation a staffing of each subject will be carried out jointly by the vocational rehabilitation counselor, the internist, the social worker, and the psychiatrist to determine if the client will be accepted for rehabilitation. Criteria for selection are presented below.

B. Criteria for selection for rehabilitation

Selection of a subject will be based on the decision of the joint staffing following the third phase of screening. Criteria will be as follows:

(1) Primary disability of alcoholism.

(2) Absence of severe physical impairment.

(3) Absence of severe brain damage.

(4) Past history of productivity.

(5) History of efforts to control drinking in past.

(6) Evidence of motivation as exhibited by degree of cooperation during screening process; for example, the subject's willingness to take Antabuse.

(7) Usual criteria used in selecting VR clients throughout State.

C. Rehabilitation procedure and staff function

The primary aim of the rehabilitation procedures is to assist the client in becoming employed and to maintain his employment.

(1) Initial procedures

The aim initially is to prohibit the individual's drinking through the use of Antabuse and by assisting the client in obtaining the daily necessities for living, food and shelter, such that the frustration that would otherwise be incurred in obtaining these necessities will not predispose the individual to resumption of the use of alcohol. Treatment of physical disabilities where present and where interfering with client's work potential will be undertaken through referral to the appropriate medical clinics at Grady Memorial Hospital. The staff at Grady Hospital will assist clients in obtaining maximum benefits in Grady Hospital's facilities.

The typical client will then, within an extremely short period after evaluation, be ready to obtain employment. The client himself will frequently be able to locate his own employment, this being facilitated by reassurances to the employer by vocational rehabilitation counselors that the client is now under treatment for his alcoholism. In other instances employment for the client will be obtained through the efforts and contacts of the vocational rehabilitation counselor or through referral to the State employment agency.

(2) Maintenance procedures

Once the initial phase of rehabilitation has been accomplished and the client is employed the major objective of maintaining the individual's employment and promoting job stability begins.

The methods whereby this goal is attained will vary with the individual client, but in general involve the following approaches:

(a) Drug therapy

Continued use of Antabuse and other medication to promote sobriety carried out by the staff psychiatrist and internist.

(b) Individual and group contact

Regular and unscheduled individual and group contact by the clients with the Vocational Rehabilitation counselors will be initiated to discuss and work out problems related to the client's work, to help resolve the realistic problems with employment and to help the client recognize what aspects of his own personality contribute to difficulty in performing his work such that the individual may learn to more adequately deal with these areas.

(c) Social Work Services

Counseling will be done both regularly and as needed with the individual clients and at times with the clients and spouses to help resolve social situations which predispose the client toward the resumption of the use of alcohol. Group therapy will be utilized to the same end and to help the client better understand and control his own behavior. The social worker will also help the client in obtaining assistance from other resources in the community where appropriate, such as welfare and social agencies.

Another of the important characteristics of the rehabilitation procedure has to do with the staff being available to the client at all times so that he can have someone to talk with and help him resolve immediately distressing and frustrating situations, thereby tending to prevent the client's return to the impulsive use of alcohol with its consequent adverse effect on his employment. In time the client will learn a more productive way of handling his problems.

(d) Joint staff conferences

Joint staff conferences will be held regularly to facilitate the rehabilitation procedures by discussing current cases in order to integrate staff efforts and modify approaches when needed.

(e) Housing

Housing provided on a rent basis or at no cost for variable periods during rehabilitation will be needed for some clients. This will be provided through the project's contact with the St. Jude's Halfway House for alcoholics and through the Salvation Army. These facilities are of particular importance for those clients who need to be reintegrated into a non-drinking social group rather than allowing them to continue to exist in a situation in which their own social contact is with people who are drinking excessively.

(3) Duration of rehabilitation procedures

Duration of an individual's contact with the project will be variable.

Cases, in general, will be closed when a client has remained steadily employed and manifests no indication of impairment in productivity from alcoholism for a period of six months.

D. Project analysis

(1) Monthly reports

Monthly reports to the Division of Vocational Rehabilitation are to be submitted indicating number of active cases and their rehabilitation status, number of new cases, number of cases closed along with their disposition, as well as information concerning number of cases seen in the second and third phases of screening. All of the information concerning cases is to be freely available to the Division of Vocational Rehabilitation.

(2) Evaluation of results

Information regarding employment and earnings is to be collected on each client for a one year period prior to acceptance on the project. Similar information will be collected while the case is active and for 12 months following closure of the case so that an evaluation of the effectiveness and cost of rehabilitation can be made.

Also the influence of the project on changing the financial burden on the various welfare agencies will be determined.

Effect of the project will be evaluated in terms of reduction in arrest rate for the individual client and for the community at large.

EMORY UNIVERSITY
VOCATIONAL REHABILITATION ALCOHOL PROJECT
41 Exchange Place, SE, Atlanta, Ga.
Dr. James Alford, Project Director

INTAKE AND SCREENING PROCEDURES

December 29, 1967
(Revised)

Phase I:

Any new patient (not known to the Project previously) or any patient whose case has been closed but has not been discussed previously in a Project Intake Staffing Conference will be received by the receptionist who will ask each patient to fill out a Project Application Form. Those patients whose cases have been closed but whose cases have previously been discussed in a Project Intake Staffing Conference will be screened by a case aide for a determination as to whether their cases should remain closed or whether they should be reopened. If it is decided, with the assistance of the Project Director, social worker, and/or Chief VR Counselor if necessary, that the case should be reopened, a determination will be made as to the point in the screening process at which the patient should be placed. Generally speaking, patients who have not had a general physical examination in the Project within the past six months will be required to have a new general medical examination.

If any patient needs help in completing the Application Form discussed above, the receptionist will call the case aide on intake duty to assist the patient with this process. If the patient indicates that he is unable to complete the form because he is presently without his eyeglasses, he will be given a pair of reading glasses for his temporary use in completing the Application. If the patient maintains that he is still unable to complete the form with the reading glasses, but could do so with his own eyeglasses, his word on this will be accepted and an accurate assessment of his vision will be postponed until later.

Regarding those patients who are obviously intoxicated or who are manifesting symptoms of alcohol withdrawal, the receptionist will keep a simple count or tally on the number of such individuals. The receptionist or the case aide will suggest to these patients, when it is appropriate to do so, that they seek treatment immediately at the Grady Hospital Emergency Clinic and return to the Project at a later time when they are sober and not suffering from withdrawal symptoms.

If the data obtained on the Application Form indicates that the patient (either new patient or a previously closed case) is ruled out by any of the eligibility criteria listed below, the case aide will then inform the patient privately (in the case aide's office rather than in the waiting room or in the hallway) that he is not eligible for services from the Project; and the patient will be given any referral assistance that is necessary and appropriate. If the case aide determines that the applicant is not excluded at this point on the basis of the eligibility criteria listed below or on the basis of other criteria which the Chief Social Worker or Chief VR Counselor might employ, the case aide will continue the usual intake interview with the patient.

The case aide will next arrange for the patient to proceed to Phase II of the screening process.

The criteria to be used in Phase I are the following:

1. Age--Any patient who is 55 years or older will be excluded.

2. Literacy--Anyone who is unable to read and write (except for visual problem to be resolved later) will be excluded.

3. Number of Arrests--Anyone who has not had a minimum of two arrests for public intoxication during the past 12-month period will be excluded.

4. Present Condition--Any Project activity on any patient who manifests symptoms of intoxication

or of withdrawal from alcohol will be deferred until the patient returns at a later date and no longer manifests such symptoms.

5. Any patient who insists that he would not consider taking Antabuse under any circumstances will be excluded.

Phase II:

Phase II of the Screening Process consists of the psychological testing and the patient's interview with the VR counselor. The testing procedures for Phase II are as follows:

1. Patients may be scheduled any day 8:30 a.m. to 3:00 p.m. for testing.

2. Patients will be given the entire battery of tests in one session. The Shipley-Hartford will be administered first; failure on this test is considered justification for termination in most cases. "Barely failing" cases and those for which there is some doubt about the validity of the Shipley-Hartford may be retested on the Otis-Lennon. A score of 75 or more on either IQ tests qualifies an applicant to take the MMPI. Caseworkers will be notified immediately via a report from the psychologist whether a patient has satisfied the Project's IQ requirement in order that either arrangements for Phase III processing can begin, or the case aide can inform the patient at this point that he cannot be accepted by the Project. (The psychologist will, in addition, transmit periodically the following information: (1) the names of those patients who have not appeared for testing following a two-week interval after making an appointment for this purpose, (2) the names of those patients who have been accepted in Phase I but who have not appeared during the past 30-day period for testing, and (3) the names of those patients who have completed

part, but not all, of the testing and who left the Project offices without authorization and failed to make another appointment for testing.)

3. MMPI results will not ordinarily be available for several days following testing. When all tests have been given, scored, and interpreted, the Psychometric Evaluation Report will be completed by the psychometrist and a copy furnished to the social work file and the VR file. Cases scheduled for staffing will be given priority.

If the patient manifests some questionable physical condition of a very serious nature, he should proceed to Phase III of the screening without completing the routine screening of Phase II.

Screening Procedures

At the completion of the psychological testing, the case aide will schedule the patient for an intake interview with the Vocational Rehabilitation Counselor, unless the patient is screened out by the testing. If the patient is screened out at this point, the case aide will inform the patient of his termination, carry out the necessary and appropriate referral assistance, and complete a Notice of Action Form showing that the case is closed as Not Feasible.

If the patient is not screened out at this point, the Vocational Rehabilitation Counselor will see this patient immediately, or as soon as possible. The case aide will transmit the patient's case record to the VR Counselor for the counselor's intake interview with the patient. Following his interview with the patient, the counselor will return the case record to the case aide. The case aide will them proceed to schedule the patient's appointments for the medical and psychiatric examinations.

Phase III:

The medical and/or psychiatric examinations will comprise this portion of the screening.

Once all this information and data gathering process is completed, the patient will be presented at the Intake Staffing Conference for further evaluation, recommendations, and disposition. The psychiatrist at the Intake Staffing Conference will be responsible for decisions regarding further psychological testing and evaluation, and this decision will be made at the time of the Intake Staffing Conference. If the case is accepted for services in the Intake Staffing Conference, the psychiatrist at the Conference, in consultation with the Chief Social Worker and Chief VR Counselor, will make the assignment of the case to the social worker and the VR counselor who will actually work with the client.

If the patient is determined to be ineligible for services through failing to meet any of the criteria to be used in Phase III of the screening (psychopathology, Antabuse contraindicated, serious physical impairment, or handicap) or is rejected in the Intake Staffing Conference, the patient will be so notified by the case aide; and, again, appropriate referral assistance will be rendered the patient by the case aide.

We would like to emphasize the following: Case aides are to be responsible for the progression of the patient through the screening process and until the patient's case has been discussed in the Intake Staffing Conference. In some instances, the case aide will be assigned certain responsibilities following the Intake Staffing Conference until the patient is transferred to one of the staff social workers.

This means that the case aide will be responsible for following closely the patient's progress through the screening process, for coordinating this process for the patient, and for making this process as constructive as possible for the patient. It will be important for the case aide to observe closely the patient's reactions to the various procedures in the screening process and to give the patient appropriate support and opportunity for ventilation of his feelings throughout the process. It will also be the responsiblity of the case aide to terminate the process and close the patient's case when the patient fails to respond sufficiently to allow the screening process to continue. The case aide will exercise as much appropriate effort as possible in assisting patients to follow through in the screening process and to prevent the drop-out of patients from the process. Needless to say, the case aides will need the full cooperation of all other members of the Project staff in order to discharge this challenging responsibility in a satisfactory manner.

Appendix B

Appendix B

SAMPLE PROPOSAL AND AGREEMENT

A Proposal for the Establishment of a Vocational Rehabilitation Unit within the Alcoholic Rehabilitation Center Butner, North Carolina

During the past several years, the Division of Vocational Rehabilitation and the Department of Mental Health have realized substantial success by working cooperatively in the rehabilitation of the mentally handicapped. Presently, the two parties share areas of common interest and responsibility in Alcoholic Rehabilitation; and, therefore, they again wish to combine and coordinate their resources and work cooperatively toward providing a more effective rehabilitation program for the alcoholic.

The program herein proposed is for the establishment of a Vocational Rehabilitation Unit within the Alcoholic Rehabilitation Center at Butner, North Carolina. The Alcoholic Rehabilitation Center is a State operated inpatient facility with a capacity of 50 patients and having approximately 600 admissions annually. The Center currently serves the entire State and offers an intensive short term (30 day) therapy program for voluntary patients. The Center's program utilizes medical, psychiatric, psychological, and social services in the approach to rehabilitation.

It has been evident for some time now that, upon completion of the 30-day program, the patient is discharged without adequate follow-up services and, in many instances, totally unprepared to meet the social, econcomic, and vocational demands of life. This point is vividly illustrated by the fact that 40% of the Center's patients are chronically unemployed and an even greater percentage are in need of vocational counseling and guidance, job placement, training, and other related services in order to make a successful adjustment to life.

These critically needed services are presently beyond the scope of the Center, and they all fall within the traditional realm of Vocational Rehabilitation. In order to meet this critical need and thereby provide a comprehensive program which would be expected to produce more effective overall results than have otherwise been experienced, a special Vocational Rehabilitation Unit based within the Center and projected into the community through a highly mobile staff will be established. The Vocational Rehabilitation Unit will be a separate entity within the Center, and it will function to combine and coordinate the services of the Center with the services of Vocational Rehabilitation. The unit will be designed, organized, and staffed to:

1. Provide a vocationally-oriented rehabilitation unit within the Center.
2. Provide continuity in the alcoholic's rehabilitation process during the transition from the Center to the community.
3. Provide a means for extending rehabilitation and follow-up services to the alcoholic until a successful adjustment to the job is made.
4. Provide a means for increasing substantially the number of alcoholics who become vocationally rehabilitated.

In order to carry out these objectives, the unit's staff will take a team approach viewing the alcoholic from the holistic viewpoint and with the basic orientation that alcoholic rehabilitation involves:

1. Medical and psychiatric rehabilitation.
2. Social, family, and interpersonal rehabilitation.
3. Vocational rehabilitation.

The staff will consist of a Unit Supervisor, a Vocational Rehabilitation Case Service Supervisor, a Social Service Supervisor, a Psychologist, two Rehabilitation Counselors, two Social Workers, and three Stenographers. All professional staff members will attend a short-term training program prior to the establishment of the unit.

Each patient at the Center will be referred to the Vocational Rehabilitation Unit for determination of eligibility and need for its services.

All patients of the Center will become reported referrals to Vocational Rehabilitation, and it is anticipated that between 300 and 500 of these referrals will become active Vocational Rehabilitation clients each year.

All patients who are found to be eligible and in need of Vocational Rehabilitation services will be offered all services normally offered other Vocational Rehabilitation clients in accordance with the State Plan. Other than the rehabilitation services specifically outlined and defined by the State Plan, the unit staff will:

1. Contribute to the patient-client's total treatment program by providing group and individual counseling in social, vocational, and personal adjustment areas.

2. Contribute to the patient-client's total evaluation program by providing psychological testing and social-vocational-family assessment.

3. Provide intensive counseling and social service for the alcoholic's family.

4. Concentrate on increasing the alcoholic's employability to a level and area conducive to good mental health.

5. Make use of vocational rehabilitation mental health resources outside of the Center, such as sheltered workshops and rehabilitation homes.

6. Help employers, local agencies, and organizations better understand alcoholics by working with Alcoholic Information Centers and other agencies concerned with the problem of alcoholism.

7. Collect research and evaluative data on the characteristics of the alcoholic by administering a battery of standardized psychological tests to each patient-client served by the unit.

The community, family, and public information aspects of the program are felt to be essential; and, therefore, the staff's time and function will be designed so as to insure that both the institutional and community aspects of the program receive adequate and appropriate attention.

The Alcoholic Rehabilitation Center will remain responsible for all in-patient diagnostic and treatment services. Patient-clients who are in need of treatment services after discharge from the Center will be provided services in their local communities through regular Section 2 case service funds in accordance with the State Plan. The unit will provide follow-up services for all clients residing within a reasonable radius of the Center, and those clients residing outside the radius will be transferred to the respective District Office of Vocational Rehabilitation upon discharge.

The Vocational Rehabilitation Unit will function as an integral part of the Division of Vocational Rehabilitation. The Unit Supervisor will be under the direct supervision of the Coordinator for the Mentally Handicapped, Division of Vocational Rehabilitation, Raleigh, North Carolina, and jointly responsible to the Medical Director of the Alcoholic Rehabilitation Center.

The Center will also provide the unit with office space, utilities, and janitorial services.

The unit will be financed on a yearly budget basis through Section 2 Vocational Rehabilitation funds. The Alcoholic Rehabilitation Center will initially assign a Unit Supervisor, a Psychologist, a Social Work Supervisor, and a Stenographer to the unit's staff and certify their salaries as the State's share of the matching ratio. Additional contributions may be made later if the program or funding arrangements are in need of alterations.

Professional and administrative personnel from the unit, the Alcoholic Rehabilitation Center, and the Division of Vocational Rehabilitation will meet periodically to review the effectiveness of the unit and to make recommendations for any changes which might be indicated. If the Vocational Rehabilitation Unit proves to be an effective approach to Alcoholic Rehabilitation, similar units will probably be incorporated into other Alcoholic Rehabilitation Centers which will soon be established throughout North Carolina.

AN AGREEMENT

I. Parties

This agreement is entered into between the Division of Vocational Rehabilitation of the North Carolina State Board of Education and the North Carolina Department of Mental Health.

II. Objectives of the Agreement

This agreement provides for the establishment and operation of a Vocational Rehabilitation Unit within the Alcoholic Rehabilitation Center, Butner, North Carolina, for the purpose of:

1. Providing a more effective program of rehabilitation services for patients of the Alcoholic Rehabilitation Center.
2. Increasing substantially the number of alcoholics who become vocationally rehabilitated.

III. Organization and Function of the Unit

The Vocational Rehabilitation Unit will be established within the Alcoholic Rehabilitation Center. It will be staffed with a Unit Supervisor, a Vocational Rehabilitation Case Service Supervisor, a Social Work Supervisor, a Psychologist, two Rehabilitation Counselors, two Social Workers, and three Stenographers. The Unit Supervisor will be under the direct supervision of the Coordinator for the Mentally Handicapped, Division of Vocational Rehabilitation, Raleigh, North Carolina, and jointly responsible to the Medical Director, Alcoholic Rehabilitation Center, Butner, North Carolina.

The unit will combine and coordinate the services of the Alcoholic Rehabilitation Center with the services of Vocational Rehabilitation and it will function to:

1. Provide a vocationally oriented rehabilitation unit within the institution.

2. Provide continuity in the alcoholic's vocational rehabilitation process during the transition from the institution to the community.

3. Provide a means for extending vocational rehabilitation and follow-up services to the alcoholic until a successful adjustment to the job is made.

IV. Rehabilitation Services Provided by the Unit

All patients of the Center will be referred to the Vocational Rehabilitation Unit where they will be screened to determine eligibility and need for services. Those patients found eligible and in need of vocational rehabilitation services will be offered all services which are normally offered other Vocational Rehabilitation clients in accordance with the State Plan. Other than those services specifically outlined in the State Plan, the unit staff will:

1. Contribute to the patient-client's total treatment program by providing group and individual counseling in social, vocational, and personal adjustment areas.

2. Contribute to the patient-client's total evaluation by providing psychological testing and social-vocational-family assessment.

3. Provide intensive counseling and social casework for the alcoholic's family.

4. Concentrate on increasing the alcoholic's employability to a level and area conducive to good mental health.

5. Work to help employers better understand alcoholism.

6. Collect research data on the characteristics of the alcoholic by administering a battery of standardized psychological tests to each patient-client. The battery will include the WAIS, MMPI, and California Psychological Inventory.

The unit's staff will provide follow-up services within a reasonable radius of the Center. Patient-clients residing outside this radius will be transferred to the respective District Office of Vocational Rehabilitation upon discharge.

V. Funding Arrangements

The Vocational Rehabilitation Unit, being an integral part of the Division of Vocational Rehabilitation, is to be financed in the same manner as other functions of the Division by the use of State and Federal matching funds as required under Section 2 of the Federal Vocational Rehabilitation Act. Financing the rehabilitation unit shall be on an annual budget basis to insure continuity of operations. To receive Federal matching funds, the Division of Vocational Rehabilitation will provide State funds equal to the State's share of planned expenditures as specified in the Federal Act. The Alcoholic Rehabilitation Center will contribute annually a specified sum as the State's share of the matching funds. The Center's contribution will be funds provided in the form of staff which can be charged directly to the unit's budget. Any contribution of funds shall be made available for expenditure at the sole discretion of the Division of Vocational Rehabilitation. The contribution by the Alcoholic Rehabilitation Center will be duly identified and accounted for and constitute the State's matching requirement of the total annual operating cost of the rehabilitation unit. The Division of Vocational Rehabilitation will maintain such accounts and supporting documents that will permit an accurate determination at any time of the status of State and Federal participation of expenditures incurred in the operation of the rehabilitation unit. The specific terms of each annual budget will be worked out jointly and agreed to in writing by the parties prior to the beginning of the fiscal year. The business manager of the Alcoholic Rehabilitation Center agrees to report monthly to the Division of Vocational Rehabilitation the amount of funds or services-in-kind which are certified to the Division.

VI. Responsibilities of the Division of Vocational Rehabilitation

1. To accept cash or in kind contributions from the Alcoholic Rehabilitation Center and use such funds as the State's portion of the matching ratio to obtain Federal funds to operate the rehabilitation unit.

2. To assign one Supervisor, two Counselors, two Social Workers, and two Stenographers to the unit's staff.

3. To provide direct administrative and professional supervision and consultation to the unit through the Coordinator for the Mentally Handicapped, Division of Vocational Rehabilitation, Raleigh, North Carolina.

4. To provide vocational rehabilitation services to all referrals from the Alcoholic Rehabilitation Center who are found to be eligible for and in need of services in accordance with the State Plan.

5. To approve all unit and case services expenditures in accordance with the State Plan.

6. To provide adequate office equipment, travel expenses, and long distance telephone services to the unit's staff.

7. To coordinate the functions of the Vocational Rehabilitation Unit with the needs of the Alcoholic Rehabilitation Center.

VII. Responsibilities of the Department of Mental Health

1. To assign one Psychologist, one Unit Supervisor, one Social Work Supervisor, and one Stenographer to the unit and designate such as the State's share for matching purposes in obtaining Federal funds to operate the unit. For further development of the program, the department may provide additional cash or in kind contributions.

2. To provide adequate office space, janitorial services, and utilities (with the exception of long distance telephone services) with which to operate the unit.

3. To provide the medical and psychiatric diagnostic and treatment services which are currently, traditionally, and legally the responsibility of the Alcoholic Rehabilitation Center.

4. To provide medical and psychiatric consultative services to the unit.

5. To make available adequate medical and psychiatric information about persons referred to the unit.

6. To coordinate the functions of the Alcoholic Rehabilitation Center with the needs of the Vocational Rehabilitation Unit.

VIII. Miscellaneous Provisions

1. All parties to this agreement are currently in compliance with the provisions of Title VI of the Civil Rights Act of 1964.

2. The terms to this agreement may be changed or modified upon mutual consent of the parties.

3. The terms of this agreement are subject to approval by the Vocational Rehabilitation Regional Office, Charlottesville, Virginia.

4. This agreement may be terminated by either party hereto upon sixty (60) days' written notice. This agreement is entered into and becomes effective on this the 2nd day of February, 1967.

N. C. Department of Mental Health	Division of Vocational Rehabilitation
Raleigh, North Carolina	Raleigh, North Carolina

Appendix C

Appendix C

REVIEW OF LITERATURE AND SELECTED REFERENCES

The purpose of this appendix is to provide the reader a brief overview of major findings and to provide references to related literature and research on alcoholism pertinent to the following categories: (1) personality factors, (2) physiological factors, (3) socio-cultural factors, and (4) effects of treatment.

Some of the major references one may find helpful are: (1) Jellinek's *The Disease Concept of Alcoholism* in which he explores the historical development of attitudes toward alcoholism as a disease. (2) Blum and Blum's *Alcoholism, Modern Psychological Approaches to Treatment* which summarizes the latest in psychological and social treatment methods of alcoholism and presents a series of far reaching recommendations for improving treatment at individual, group and community levels. (3) Ruth Fox's *Alcoholism, Behavioral Research, Therapeutic Approaches* in which an attempt is made to present a comprehensive picture of recent behavioral and therapeutic approaches to alcoholism. (4) Pittman's *Alcoholism* in which is presented results from recent scientific studies on alcoholism and clinical experiences of practitioners in the field. (5) Booklet edited by Tatham for HEW (RSA), *Alcoholism Rehabilitation, Local-State-Federal*, which reports proceedings of the National Conference on alcoholism and vocational programs held at the University of Chicago, January 5-7, 1965. (6) The Classified Abstract Archive of the Alcohol Literature (CAAAL) which has been in operation for more than 25 years and is maintained by the Rutgers University Center of Alcohol Studies. The Archive is first of all, a collection of abstracts and scientific literature. Generally, the area covered is the uses of alcohol by man and the effects of such use.

Personality Factors

Extensive research has been devoted to isolating the "common traits" that make up what many believe is the "alcoholic personality." There has been no conclusive agreement on the identity of these traits, nor on whether they may be the causes or the results of problem drinking.

In 1950, Sutherland et al. reviewed the literature at that time and concluded that no alcoholic "personality type" could be found on the basis of Rorschach Protocols or non-projective psychological tests.

Armstrong (1958) agreed with the conclusions reached by Sutherland et al. but cautioned:

> ...it would seem premature to abandon the search because of failure to date to determine adequate methods or to discover the appropriate investigative tools...the quest for an alcoholic personality or constellation of frequently predominant characteristics in alcoholism has barely begun. (p. 47)

In 1962, Popham and Schmidt conducted a more comprehensive review of the research relating to personality factors and alcoholism. The authors concluded that the studies to date of the social and personality characteristics of alcoholics have failed to show that they differ significantly from non-alcoholics.

Personality Factors - References

Armstrong, J. D. The search for the alcoholic personality. Annals of the American Academy of Political and Social Science, 1958, 315, 40-47.

Berger, E. Personality traits of alcohol addicts. Quarterly Journal of Studies on Alcohol, 1946, 7, 356-359.

Bigelow, N. J. T., Lehrmann, S. R., & Palmer, J. N. Personality in alcoholic disorders; acute hallucinosis and delirium tremens. Psychiatric Quarterly, 1939, 13, 732-740.

Blum, M. B., & Blum, R. H. Alcoholism, modern psychological approaches to treatment. San Francisco, Calif.: Jossey-Bass Inc., 1967.

Button, A. D. The psychodynamics of alcoholism: A survey of 87 cases. Quarterly Journal of Studies on Alcohol, 1956, 17, 443-460.

Hall, R. A. Obsessive-compulsive features in a case of chronic alcoholism. Psychoanalytic Review, 1950, 37, 73-78.

Hart, H. H. Personality factors in alcoholism. Archives of Neurology and Psychiatry, 1930, 24, 116-134.

Higgins, J. W. Psychodynamics in the excessive drinking of alcohol. Archives of Neurology and Psychiatry, 1953, 69, 713-726.

Karpman, B. The alcoholic woman: Case studies in the psychodynamics of alcoholism. Washington: Linacre Press, 1956.

Machover, S., & Puzzo, F. S. Clinical and objective studies of personality variables in alcoholism. I. Clinical investigation of the alcoholic personality. Quarterly Journal of Studies on Alcohol, 1959, 20, 505-519.

Machover, S., & Puzzo, F. S. Clinical and objective studies of personality variables in alcoholism. II. Clinical study of personality correlates of remission from active alcoholism. *Quarterly Journal of Studies on Alcohol*, 1959, *20*, 520-527.

Machover, S., Puzzo, F. S., Machover, K., & Plumean, F. Clinical and objective studies of personality variables in alcoholism. III. An objective study of homosexuality in alcoholism. *Quarterly Journal of Studies on Alcohol*, 1959, *20*, 528-542.

Popham, R. E., & Schmidt, W. *A decade of alcoholism research: A review of the alcoholism and drug addiction research foundation of Ontario, 1951-1961*. Toronto: University of Toronto Press, 1962.

Rosenman, S. The skid row alcoholic and the negative ego image. *Quarterly Journal of Studies on Alcohol*, 1955, *16*, 447-473.

Sutherland, E. H., Schroeder, H. G., & Tordella, C. L. Personality traits and the alcoholic: A critique of existing studies. *Quarterly Journal of Studies on Alcohol*, 1950, *11*, 547-561.

Witkin, H., Karp, S., & Goodenough, D. Dependence in alcoholics. *Quarterly Journal of Studies on Alcohol*, 1959, *20*, 493-504.

Physiological Factors

Much research has been done in an attempt to find chemicals in specific beverages which might be the causative factors in alcohol addiction, or physiological, nutritional, metabolic or genetic defects which might explain excessive drinking. None of these attempts have been very successful (Mendelson & La Dou, 1964).

Although alcoholism occurs frequently in the children of alcoholics, and may thus seem to have a hereditary basis, it can also occur in the children of abstainers (Bleuler, 1955). Children of alcoholics are less likely to become alcoholics if they are raised away from their parents (Jellinek, 1954; Roe, 1954). This has supported the belief that alcoholism is related more to environmental than to genetic factors.

Some researchers have postulated that alcoholism is caused by vitamin deficiencies or hormonal imbalances. Research by Dr. Roger Williams (1959) and his associates at the University of Texas has demonstrated that increased alcohol intake can be induced in experimental animals by such deficiencies. Research supports the conclusion that the nutritional and hormonal deficiencies observed in far-advanced alcoholics appear to be the results rather than causes of excessive drinking (Mendelson & La Dou, 1964).

Although it has been frequently said that alcoholics are unable to metabolize alcohol as rapidly as normal individuals, Mendelson's research (1964) indicated that many alcoholics actually metabolize it more rapidly, especially when they are drinking heavily. However, there is really no conclusive evidence that alcoholics metabolize alcohol differently.

It has been postulated that the cause of alcoholism is "alcohol." This explanation presents many difficulties in that it is impossible to explain the variation in rate of alcoholism among drinkers according to sociological factors such as cultural, economic, ethnic, and geographic differences.

Physiological Factors - References

Bleuler, M. Familial and personal background of chronic alcoholics, in Diethelm, O. Etiology of chronic alcoholism. Springfield, Ill.: Thomas, 1955.

Fox, V., & Smith, M. A. Evaluation of a chemopsychotherapeutic program for the rehabilitation of alcoholics. Quarterly Journal of Studies on Alcohol, 1959, 20, 767-780.

Goodman, L. S., & Gilman, A. (Eds.) The pharmacological basis of therapeutics. (2nd ed.) New York: Macmillan, 1955.

Gross, A. The psychic effects of toxic and toxoid substances. International Journal of Psychoanalysis, 1935, 16, 425-438.

Jellinek, E. M. Heredity of the alcoholic, in Yale University Center of Alcoholic Studies: Alcohol, science, and society. Quarterly Journal of Studies on Alcohol, New Haven, Conn., 1954.

Mendelson, J. H., & La Dou, J. Experimentally induced chronic intoxication and withdrawal in alcoholics. Part 2. psychophysiological findings. Quarterly Journal of Studies on Alcohol, 1964, 14, (suppl. 2).

Partanen, J., Bruun, K., & Markkanen, T. Inheritance of drinking behavior. Finnish Foundation for Alcohol Studies, Helsinki, 1966.

Robbins, B. S. A note on the significance of infantile nutritional disturbances in the development of alcoholism. Psychoanalytic Review, 1935, 22, 53-59.

Roe, A. Children of alcoholic parents raised in foster homes, in Yale University Center of Alcohol Studies: Alcohol, science, and society. Quarterly Journal of Studies on Alcohol, New Haven, Conn., 1954.

Williams, R. J. Alcoholism: The nutritional approach. Austin, Texas: University of Texas Press, 1959.

Socio-Cultural Factors

Although intensive research has up to this point failed to identify a simple chemical, physiological, or emotional cause of alcoholism, studies in the area of sociology, but also involving physiology, psychology, nutrition, cultural anthropology and epidemiology are regarded by scientists as illuminating. These studies have aimed at determining why alcoholism is widespread in some ethnic groups but rare in others.

Those with the highest reported rates of alcoholism are classed as the high incidence groups. They usually include the Northern French, the Americans, especially the Irish-Americans, the Swedes, the Swiss, the Poles, and the Northern Russians.

In contrast, the relatively low-incidence groups include the Italians, some groups of Chinese, Orthodox Jews, Greeks, Portuguese, Spaniards, and the Southern French.

Studies have shown that low rates of alcoholism among some groups of people cannot all be attributed to abstinence. For example, Mormans and Moslems, because of religious beliefs do not drink and therefore have low rates of alcoholism. However, among groups that have a high percentage of drinkers such as Italians and Jews, the rate of alcoholism is relatively low (Yolles & Mendelson, 1967).

In general, the research has shown that for the groups that use alcohol to a significant degree, the lowest incidence of alcoholism is associated with certain habits and attitudes surrounding its use (Yolles & Mendelson, 1967):

1. The children of the family are exposed to alcohol early in life, within the framework of a strong family or religious group. The beverage used is served in very diluted form and in small quantities.

2. The beverages used commonly are those that contain relatively large amounts of non-alcoholic components.

3. The beverage is usually consumed with meals and is frequently considered as a food.

4. The parents set a consistent example of moderate drinking.

5. Drinking is considered neither a virtue nor a sin.

6. Drinking is not viewed as a means of expressing one's adulthood or manhood.

7. One is not regarded as deviant if he abstains.

8. Use of alcohol to excess is not socially acceptable.

9. There is usually explicit or implicit agreement among the members of the group as to the ground rules of drinking.

Socio-Cultural Factors - References

Bales, R. F. Cultural differences in rates of alcoholism. Quarterly Journal of Studies on Alcohol, 1946, 6, 480-499.

Berreman, G. D. Drinking patterns of the aleuts. Quarterly Journal of Studies on Alcohol, 1956, 17, 503-514.

Blane, H. T., & Meyers, W. R. Social class and establishment of treatment relations by alcoholics. Journal of Clinical Psychology, 1964, 22, 287-290.

Bunzel, R. The role of alcoholism in two Central American Cultures. Psychiatry, 1940, 3, 361-387.

Calhoun, J. R. Population density and social pathology. Scientific American, 1962, 20, 139-148.

Chassell, J. Family constellation in the etiology of essential alcoholism. Psychiatry, 1938, 1, 473-503.

Devereux, G. The function of alcohol in Mohave Society. Quarterly Journal of Studies on Alcohol, 1948, 9, 207-251.

Field, P. B. A new cross-cultural study of drunkenness. In D. J. Pittman & C. R. Snyder (Eds.), Society, culture, and drinking patterns. New York: Wiley, 1962.

Heath, D. B. Alcohol in a Navajo community. Harvard College thesis, 1952.

Heath, D. B. Drinking patterns of the Bolivian Camba. Quarterly Journal of Studies on Alcohol, 1958, 19, 491-508.

Horton, D. The function of alcohol in primitive societies: A cross-cultural study. Quarterly Journal of Studies on Alcohol, 1943, 4, 199-320.

Mathias, R. E. S. An experimental investigation of the personality structure of chronic alcoholics, alcoholics anonymous, neurotic and normal groups. University of Buffalo thesis, 1955.

Pittman, D. J., & Snyder, C. R. (Eds.) *Society, culture, and drinking patterns*. Wiley, 1962.

Wahl, C. W. Some antecedent factors in the family histories of 109 alcoholics. *Quarterly Journal of Studies on Alcohol*, 1956, *17*, 643-654.

Yoles, S. F., & Mendelson, J. H. (Eds.) *Alcohol and alcoholism*. Washington, D. C. U. S. Department of Health, Education and Welfare, Public Health Service Publication No. 1640, 1967.

Effects of Treatment

One of the most significant studies on treatment was conducted by Wallerstein and his associates (1957). Antabuse, conditioned response therapy, and hypnotherapy, were used with different groups of patients, and changes in these groups were compared with changes in a control group. Since the patients in the control group were also in the hospital and did not want to be left out of the experiment, they were told that they were getting milieu therapy. These latter patients did not do as well as any of the other groups, but the striking fact is that they improved, doing almost as well as the patients in the experimental group. The control group took part in discussion groups on the ward, was regarded with some interest by the hospital staff, and knew that they were taking part in an experiment. This suggests that a great deal can be done for patients on alcoholic wards merely by offering them a humane environment--one in which there is mutual respect, where genuine relationships with other individuals are possible, and where they are able to feel that they are a part of a group.

The research to date indicates that various treatment programs embracing various kinds of treatment usually lead to improvement in some areas of the individual's functioning. The striking fact is that all therapies seem to do some good. However, it is impossible to make conclusive statements at this time as to which is more effective. In almost all investigations, treatment is carried out in settings where it is impossible to control all of the extraneous variables. It is, therefore, impossible to say precisely what were the major factors in behavioral changes.

Effects of Treatment - References

Belden, E. A therapeutic community for hospitalized alcoholics. California's Health, 1962, 20, 89-90.

Block, M. A. A program for the homeless alcoholics. Quarterly Journal of Studies on Alcohol, 1962, 23, 644-649.

Blum, M. B., & B.um, R. H. Alcoholism, modern psychological approaches to treatment. San Francisco, Calif.: Jossey-Bass, Inc., 1967.

Bowman, K. M. Past, present and future in the treatment of drug addiction. Comprehensive Psychiatry, 1963, 4, 145-149.

Brenman, M., & Gill, M. M. Hypnotherapy. New York: International University Press, 1947.

Cherkas, M. S. Synanon Foundation--A radical approach to the problem of addiction. American Journal of Psychiatry, 1965, 121, 1065-1068.

Feldman, H. The ambulatory treatment of alcoholic addicts: A study of 250 cases. British Journal of Addiction, 1959, 55, 121-127.

Fox, R. Group psychotherapy with alcoholics. International Journal of Group Psychotherapy, 1962, 12, 56-63.

Freedman, A. M. Treatment of drug addiction in a community general hospital. Comprehensive Psychiatry, 1963, 4, 199-207.

Knight, R. P. The dynamics and treatment of chronic alcohol addiction. Bulletin of the Menninger Clinic, 1937, 1, 233-250.

Pittman, D. J. (Ed.) Alcoholism. New York: Harper & Row, 1967.

Schilder, P. *Psychotherapy of addiction*. New York: Norton, 1938.

Shea, J. E. Psychoanalytic therapy and alcoholism. *Quarterly Journal of Studies on Alcohol*, 1954, *15*, 569-605.

Smart, R. G., & Storm, T. The efficacy of LSD in the treatment of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1964, *25*, 333-338.

Wallerstein, R. S. *Hospital treatment of alcoholism: A comparative experimental study*. New York: Basic Books, 1957.

Appendix D

Appendix D

RESEARCH AND DEMONSTRATION PROJECTS ON ALCOHOLISM FUNDED BY RSA, 1967

University of Utah Salt Lake City, Utah 84112 Joseph P. Kesler, M. D. (256-58-2)*	To study the vocational history of alcoholic patients and to demonstrate the feasibility of utilizing a rehabilitation center in the treatment and vocational rehabilitation of alcoholics.
Volunteers of America of Los Angeles, Inc. 333 S. Los Angeles Street Los, Angeles, Calif. 90013 Walter C. Hart (284-58-3)*	To demonstrate the employability of a group of chronic alcoholic men through the utilization of a multi-disciplined professional staff in a service center.
Conn. Comm. on Alcoholism 412 Orange Street Room 205 New Haven, Conn. 06511 D. P. Miller, Ph.D. (403-59-1)*	To plan a study of the vocational rehabilitation of alcoholics through evaluation and analysis of rehabilitation counseling and other services.
National Council on Alcoholism 2 East 103rd Street New York, New York 10029 Margaret B. Bailey, D.S.W. (418-60-3)*	A demonstration of the value of vocational counseling in a psychiatrically oriented rehabilitation program for alcoholics.

*Explanation: I. E. (2042-M-66-4) refers to project number 2042 in the Medical category which began operation in 1966 and is expected to be active for four years. An Asterisk follows the numerical series for those projects which have been completed.

The Salvation Army Men's Social Service Center 1500 Valencia Street San Francisco, Calif. 94110 George W. Duplain (616-61-5)*	To demonstrate the effectiveness of a long-term in-residence vocationally oriented program, in both rural and urban semi-controlled environments, for the rehabilitation of selected alcoholics.
Florida Alcoholic Rehab. Program P. O. Box 1147 Avon Park, Fla. 33825 James H. Williams, Ph.D. (640-61-3)*	To analyze and evaluate the collaborative techniques used by a State alcoholism program and State rehabilitation services in rehabilitating 200 alcoholic patients.
University of California 405 Hilgard Los Angeles, Calif. 90024 Jean S. Felton, M. D. (726-61-3)*	To study career patterns of alcoholics in order to identify the relationship between drinking and vocational adjustment.
University of California School of Public Health Los Angeles, Calif. 90024 J. S. Felton, M. D. (1146-63-3)*	To identify and study personality traits which differentiate between alcoholic recidivist prisoners who return to self-supporting employment and those who are unable to attain this degree of rehabilitation.
State of Florida Alcoholic Rehabilitation Program P. O. Box 1147 Avon Park, Fla. 33825 James H. Williams, Ph.D. (1472-65-2)	To assess follow-up outcome of alcoholics receiving collaborative treatment from a State rehabilitation program and a State division of vocational rehabilitation.
Temple University Philadelphia, Pa. 19122 Walter Stanger, Ph.D. (1611-65-3)	To evaluate programs for the rehabilitation of homeless alcoholic men.

Chicago Ed. Television Association 1761 E. Museum Drive Chicago, Ill. 60637 Edward L. Morris (1636-64-1)*	To develop plans for a series of educational television programs on the problems and treatment of alcoholism and the rehabilitation of alcoholics.
Oregon State Board of Control Mental Health Division Room 5, State Capitol Salem, Oregon 97301 Robert R. Wippel (1657-64-1)*	To plan a demonstration of comprehensive rehabilitation services available for alcoholic offenders and to evaluate the effects of these services.
Chicago Ed. Television Association 1761 E. Museum Drive Chicago, Ill. 60637 Edward L. Morris (1701-65-1)*	To produce a series of television programs on alcoholism, available treatment facilities and services.
Hofstra University 1000 Fulton Avenue Hempstead, L. I. New York 11550 Matthew N. Chappell, Ph.D. (1755-65-3)	A project to produce a series of films for instructors and professional training centers on the subject of alcoholism rehabilitation.
Multnomah County Multnomah County Courthouse 1021 S. W. Fourth Avenue Portland, Oregon 97204 Robert R. Wippel (2045-G-66-3)	To study the effectiveness of planned use of community services for a select group of recidivist alcoholic offenders remanded by the courts.
Centenary College of La. P. O. Box 4188 Centenary Station Sherveport, La. 71104 W. F. Pledger, Ph.D. (2072-G-67-1)	A planning project to determine the feasibility of developing a program of vocational rehabilitation services for alcoholic municipal public offenders.

N. D. Comm. on Alcoholism State Capitol Bismarck, N. D. 58501 Bernard Larsen (2112-G-66-3)	To demonstrate the effectiveness of a community information, counseling, and referral center for alcoholics.

Reference:

Research and Demonstration Projects an annotated listing, 1967, Vocational Rehabilitation Administration, U. S. Department of Health, Education and Welfare, Washington, D. C.

Appendix E

Appendix E

EXPANSION GRANTS OR INNOVATION PROJECTS FUNDED BY RSA, 1968

Arizona	Expansion grant for the rehabilitation of the alcoholic public offender.
California	Department of Rehabilitation operates a center for the rehabilitation of alcoholics in Sacramento and also has a program in cooperation with the State program for alcoholics in Los Angeles (Section 2).
Connecticut	Innovation grant for a cooperative project with the Mental Health Department on alcoholism and drug dependence.
District of Columbia	Expansion, for vocational rehabilitation services at Lorton. A grant has also been made to the D. C. Health Department to operate a halfway house for those returning from the treatment center at Occoquan. The D. C. Department of Rehabilitation provides the staff.
Georgia	Expansion grant for the chronic drunk offender, at Emory University Hospital.
Iowa	Expansion grant to operate three transitional houses for the alcoholic and State D. V. R. has committed $75,000 a year of basic support money for services. O. E. O. supports the various treatment centers throughout the State.
Kansas	Innovation, to combat alcoholism at Kansas Association for Alcoholic Treatment Inc., at Valley Hope Treatment Center, Norton. The Central Kansas Alcoholic Foundation has a Laird project to establish a center.

Louisiana	A project is supported through Section 2 at Forrest Glen Alcoholic Center in Alexandria.
Minnesota	D. V. R. provides some support to St. Francis halfway house for alcoholics at Wilman. They plan to develop a new establishment at Crookston at a cost of up to $150,000.
New Hampshire	Expansion, for Intermediate Residential Facility for rehabilitation of alcoholics with New Hampshire Division of Health, Program on Alcoholism.
New Mexico	Expansion, for a community approach to alcoholism with Alcoholism Research and Training Inc.
North Dakota	Expansion, for services to alcoholics through Heartview Foundation. Also an R & D project with North Dakota Commission on Alcoholism - To demonstrate the effectiveness of a community information, counseling, and referral center for alcoholics.
North Carolina	Innovation, at the Mecklinburg County Alcoholic Board in Charlotte.
Pennsylvania	An E & I project provides for special counselors in the field of alcoholism.
South Carolina	Has an Expansion grant at the Alcoholic Rehabilitation Center in Florence.
Texas	Innovation grant at the Psychiatric Institute in Houston where they are developing a new program for alcoholics.

Washington	In Kings County, Washington, there is a three-pronged program with State D. V. R., State Health Department and the Sheriffs office operating a rehabilitation program at Cedar Hills Center.
Wisconsin	Innovation, for court referred alcoholics in Dane County.

Appendix F

Appendix F

TRAINING COURSES
1968

General background courses, with special workshops for special disciplines:

RUTGERS SUMMER SCHOOL OF ALCOHOL STUDIES
(June 30 - July 19)
Smithers Hall, Rutgers - The State University
New Brunswick, New Jersey 08903

SOUTHEASTERN SCHOOL OF ALCOHOL STUDIES
(August 12 - 16)
Held at University of Georgia, Athens, Georgia
For information write to:
Mr. James B. Harkins, Jr., Director
Division of Alcoholism
Department of Mental Health
715 State Office Building
Montgomery, Alabama 36104

MIDWEST INSTITUTE OF ALCOHOL STUDIES
(June 16 - 21)
Held at Northwestern University
For information write to:
Mr. William N. Becker, Assistant Chief
Division of Alcoholism
301 State Office Building
Springfield, Illinois 62706

UNIVERSITY OF UTAH SCHOOL OF ALCOHOL STUDIES
(June 16 - 21)
P. O. Box 473
Salt Lake City, Utah 84110

UNIVERSITY OF TEXAS INSTITUTE OF ALCOHOL STUDIES
(July 14 - 19)
808 Sam Houston Office Building
Austin, Texas 78701

NORTHEAST INSTITUTE OF ALCOHOL STUDIES
(June 23 - 28)
Center of Alcohol Studies, Smithers Hall
Rutgers - The State University
New Brunswick, New Jersey 08903

FLORIDA SCHOOL OF ALCOHOL STUDIES
Florida Alcoholic Rehabilitation Program
P. O. Box 1147
Avon Park, Florida
SOUTH FLORIDA DIVISION (August 18 - 21)
Boca Raton
CENTRAL FLORIDA DIVISION (September 15 - 18)
De Land
NORTH FLORIDA DIVISION (October 6 - 9)
St. Theresa

INTERNATIONAL SCHOOL OF ALCOHOL STUDIES
University of North Dakota
Bernard Larsen, Director
North Dakota Commission on Alcoholism
Bismarck, North Dakota 58501

Special training course, "Alcoholism and Community Action":

At Columbia University - Teachers College
(June 3 - 13)
Sponsored by the National Council on Alcoholism
For information write to:
Mr. William Ferguson, Director
Community Services
National Council on Alcoholism
2 East 103 Street
New York, New York 10029

An orientation to the attitudes and techniques useful in the rehabilitation of the alcoholic:

The Georgian Clinic (1 week course)
1260 Briarcliff Road, N. E.
Atlanta, Georgia 30306
Stipends are available for eligible professional persons: Direct requests for information to:
Mrs. Sally Mellon

Appendix G

Appendix G

FILMS FOR LOAN

Title	May be Obtained From
1. Alcohol and the Human Body	Encyclopedia Britannica Films, Inc. 202 E. 44th Street New York, New York
2. Mental Health	Encyclopedia Britannica Films, Inc. 202 E. 44th Street New York, New York
3. Alcoholism, The Revolving Door	SKF Film Center National Council on Alcoholism 2 East 103rd Street New York, New York
4. Anger at Work	International Film Bureau 332 South Michigan Avenue Chicago, Illinois
5. Roots of Happiness	International Film Bureau 332 South Michigan Avenue Chicago, Illinois
6. Feelings of Depression	McGraw-Hill Book Company Text-Film Division Highstown, New Jersey
7. Who's Boss	McGraw-Hill Book Company Text-Film Division Highstown, New Jersey
8. Feelings of Rejection	McGraw-Hill Book Company Text-Film Division Highstown, New Jersey

9.	Feelings of Hostility	McGraw-Hill Book Company Text-Film Division Highstown, New Jersey
10.	Overdependency	McGraw-Hill Book Company Text-Film Division Highstown, New Jersey
11.	David, Profile of a Problem Drinker	McGraw-Hill Book Company Text-Film Division Highstown, New Jersey
12.	To Your Health	World Health Organization Center for Mass Communications 1125 Amsterdam Avenue New York, New York
13.	Mr. Finley's Feelings	Metropolitan Life Insurance Company Association Films, Inc. Broad at Elm Ridgefield, New York
14.	How Long the Night	Methodist Board of Temperance 100 Maryland Avenue Washington 2, D. C.
15.	For Those Who Drink	L. L. Cromien and Co., Inc. 652 Book Building Detroit 26, Michigan
16.	Out of Orbit	Jam Handy Organization 2861 East Grand Boulevard Detroit, Michigan
17.	Full Circle	International Film Bureau, Inc. 332 South Michigan Avenue Chicago, Illinois
18.	Portrait of a Man	Association Films, Inc. Metropolitan Life Insurance Co. Broad at Elm Ridgefield, New York

19.	Alcoholism (Shows alcohol as a social and industrial problem.) 22 min. TMIS-912	Communicable Disease Center Attn: Public Health Service Audiovisual Facility Atlanta, Georgia
20.	The Mask (Informs the police that alcohol may mask symptoms of both physical and mental disorders.) 33 min. MIS-874	Communicable Disease Center Attn: Public Health Service Audiovisual Facility Atlanta, Georgia

Films Obtainable from:

Film Library
Center for Continuing Education
University of Georgia
Athens, Georgia 30601

1.	Alcoholism	Presents some causes of excessive drinking. Describes various forms of treatment and role of the public clinic. 22 min. EBF
2.	Beneficent Reprobate	Treats the uses and effects of alcohol in industry and in relation to the central nervous system of the human body. 40 min. WCTU
3.	Blood Money	Pictures an alcoholic on skid row. 5 min.
4.	Family Affair	Introduces five members of the alcoholic family and demonstrates the characteristics they have in common. 12 min.

5.	Payoff	Shows the harmful effects to the body through drinking alcoholic beverages. 20 min.
6.	Problem Drinkers	Shows the work of Alcoholics Anonymous and the community's responsibilities in treating alcoholism. 19 min. MOT
7.	Skid Row	A documentary description of life on skid row in Chicago. 21 min. WCTU
8.	To Your Health	Investigates what alcohol is, what causes drunkenness, what makes people drink. Presented in entertaining cartoon style; can be used with all age groups. 10 min.
9.	Theobald Faces the Facts	A cartoon film which answers some commonly misunderstood questions about the use of alcoholic beverages. 13 min.
10.	What About Alcohol?	Teen-agers discuss problems involved in the use of alcohol. 10 min. WCTU

FILMS FOR PURCHASE

May Be Purchased from:

Palomar Productions
415 Lexington Avenue
New York, New York

Title	Series on Rehabilitation of the Alcoholic Sponsored by RSA
The Fifteenth American	1. Group Therapy 2. Rehabilitation of the Alcoholic through Individual Therapy 3. The Interdisciplinary Approach to Rehabilitation of the Alcoholic 4. Lay Treatment Procedures 5. The Rehabiliation Counselor in various Rehabilitation Settings 6. Survey of Rehabilitation of the Alcoholic 7. Alcohol Education: "It's up to You"

Appendix H

Appendix H

ALCOHOLISM: TREACHEROUS BUT TREATABLE*

REASSESS OUR OWN ATTITUDES

A. See the Person Behind the Bottle

1. Treatment need not be frustrating and overly time-consuming if we set realistic objectives.

2. Alcoholism is a medical disability which must be confronted.

*Vernelle Fox, M.D., Director, Georgian Clinic, L. Guy Chelton, M.D., and Charles Whisnat, M.D. (The information presented in this appendix is from a display designed by the above named physicians. The medical emphasis is provided to aid physicians in treating patients suffering from alcoholism.)

B. Limits of Physician's Treatment: Realistic Considerations

1. Not a cure - only part of total rehabilitative effort, total treatment requires more than medical resources.
2. You need not meet patient's every demand.
3. You need not feel obliged to "rescue" patient at every turn.
4. You should not become consumed - beyond office hours, in financial loss, or in family expectations.

C. The First Step: To Understand the Problem as a Complex Illness

Alcoholism is most commonly an intermix of these factors.

Physiological	Sociological	Psychological
Loss of tolerance and adequate ability to metabolize alcohol	Ingesting alcohol as a means of adjusting to a social system	Drinking behavior a mask for underlying dynamics

Alcohol is "different" - physically and psychologically - for the alcohol-dependent patient.

D. The Physician's Responsibility to the Alcohol Dependent

1. To treat this patient with the same attitude you have toward diabetic, arthritic, or cardiac patients.
2. To render objective medical service.
3. To tailor flexible, specific treatment to individual patient needs.

You must weigh

Dependency

Physiological Sociological Psychological

Which predominates for your patient?

E. Medical Management a Part of Total Rehabilitation

Diagnosis - A time for RAPPORT: "Your body is unable to metabolize alcohol adequately."

NOT ACCUSATION: "You're an alcoholic."

F. Acute Detoxification

Preferably in the hospital first 5-7 days, but can be accomplished with daily office visits.

Patient away from crisis situation.

Maximum medical diagnosis and treatment.

Evaluate *his* illness and *his* situation.

Begin planning with him for his continuing treatment.

G. Continuing Alertness to Possibility of Pitfalls

1. Despite ability to present "picture" of intactness and self-control, most patients are unable to remain abstinent without medical support.

2. Periods of severe tension and/or depression usually recur during first two to three years.

3. Alcohol-dependent patient is also prone to sedative dependence. Too frequently medication prescribed to relieve tension or depression leads to mixed alcohol and drug abuse.

4. A word of caution: Watch for patient requests for specific sedative drugs.

5. In our ten years of clinical experience, only the following medications have not demonstrated addictive liability.
   a. Antianxiety agents
      Phenothiazines (Promazine HCl* usually most effective)
      Hydroxyzine**
   b. Antidepressants
      Amitriptyline HCl† (most frequently useful)
      Imipramine HCl††

H. Rehabilitative Services Available...total team effort for total rehabilitation

1. Alcoholics Anonymous (AA)
2. Al-Anon and Al-teen
3. Vocational Rehabilitation
4. Alcoholism Information Centers (AIC)
5. Industrial Programs
6. Community Programs
7. Mental Health Associations

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*Sparine®
**Atarax®; Vistaril®
†Elavil®
††Tofranil®

8. Religious Organizations
9. Visiting Nurse Associations
10. Family Service Associations
11. Welfare Department
12. Other Government Programs

I. Physician's Role

1. Understanding characteristics of each patient.

2. Setting realistic objectives:
    a. Acute and continuing medical management.
    b. Patience is paramount - no "quick" resolution to the problem
    ...relapse does not mean failure!

Conditions	Treatments
1. Acute withdrawal symptoms. (Shakes, hallucinations, DT's, etc.)	1. Dosage in proportion to severity of symptoms: Promazine HCl 50 to 100 mg. intramuscularly (I.M.) immediately (stat.); then 50 to 100 mg by mouth (p.o.) every 4 hours (q. 4 h.) as desired (p.r.n.) Diphenylhydantoin 100 mg. 4 times a day (q.i.d.) Hydroxyzine 100 mg q. 4 h. p.r.n. Sedative (Chloral Hydrate 500 mg. or Meprobamate 800 mg.) at the hour of sleep (h.s.) if needed for first 2-3 nights only. High potency vitamins I.M. daily High protein, high caloric diet
2. Frequent concomitant situations. (Intermediate brain syndromes, hepatocellular damage, anemia, gastritis, diabetes, neuritis, pancreatitis, emphysema, myocardiopathy, fractures, burns, and other trauma.)	2. Treat the situation as with any other patient.

Conditions	Treatments
3. Craving for alcohol.	3. Disulfiram (when sober - at least 12 hours abstinence). Continued as needed. 0.5 Gm. once daily - in the morning (a.m.) or h.s.
4. Severe tension periods with intermittent depressive moods. Depression states can often be anticipated and frequently coincide with previous drinking patterns (e.g. every 2-3 mos.)	4. Continuing supportive care indefinitely (usually one year) Disulfiram 0.5 Gm. daily if required - plus (a) In severe tension/anxiety - Promazine HCl orally 50 mg. three times a day (t.i.d.) (Range: 25 mg. t.i.d. - 100 mg. q.i.d.) - 100 mg. h.s. (b) In depression periods - substitute for "tension regimen" above as follows: Amitriptyline - 25 mg. t.i.d. (Range: 10 mg. t.i.d. - 25 mg. q.i.d.) Promazine - 100 mg. h.s. When depression subsides discontinue - treat tension manifestations as above (4a) when required.

Conditions	Treatments
5. Underlying psychological and/or interpersonal problems.	5. Psychological testing, psychiatric evaluation. Not always required - but refer when judgment dictates.

Appendix I

Appendix I

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References

REFERENCES

Abrams, S. An evaluation of hypnosis in the treatment of alcoholics. American Journal of Psychiatry, 1964, 120, 1160-1165.

Acherknecht, E. Primitive medicine and culture pattern. Bulletin of the History of Medicine, 1942, 11, 503-521.

Agrin, A. Who is qualified to treat the alcoholic? A discussion. Quarterly Journal of Studies on Alcohol, 1964, 25, 347.

Aichhorn, A. Wayward Youth. New York: Viking, 1936.

Alcoholics anonymous. New York: Alcoholics Anonymous World Service, 1960.

Alcoholics anonymous comes of age: A brief history of alcoholics anonymous. New York: Alcoholics Anonymous Publishing, 1957.

Apple, D. (Ed.) Social studies of health and sickness. New York: McGraw-Hill, 1960.

Armstrong, R. G. A review of the theories explaining the psychodynamics and etiology of alcoholism in men. Psychology Newsletter, New York University, 1959, 10, 159-171.

Asch, S. E. Social psychology. New York: Prentice-Hall, 1952.

Ash, P. The reliability of psychiatric diagnosis. Journal of Abnormal and Social Psychology, 1959, 44, 272-276.

Associate of the British Society of Addiction. The nursing of alcoholic patients. British Journal of Addiction, 1947, 44, 75-78.

Ayerst Laboratories. Antabuse toxicity. Bibliography compiled by Ayerst Laboratories. New York: 1961.

Azima, H. Sleep treatment. In J. H. Masserman & J. L. Moreno (Eds.), *Progress in psychotherapy*. Vol III. New York: Gune & Stratton, 1958.

Azin, N. H., & Holtz, W. C. Punishment during sixth-interval reinforcement. *Journal of Experimental Animal Behavior*, 1961, *4*, 343-347.

Bailey, M., Haberman, P., & Sheinberg, J. Identifying alcoholics in population surveys. *Quarterly Journal of Studies on Alcohol*, 1966, *27* (2), 300-315.

Bales, R. F. The therapeutic role of alcoholics anonymous as seen by a sociologist. In D. J. Pittman & R. R. Snyder (Eds.), *Society, culture and drinking patterns*. New York: Wiley, 1962.

Balint, M. *The doctor, his patient and the illness*. New York: International Universities Press, 1957.

Belden, E. A therapeutic community for hospitalized alcoholics. *California's Health*, 1962, *20*, 89-90.

Belden, E., & Hitchen, R. The identification and treatment of an early deprivation syndrome in alcoholics by means of LSD-25. *American Journal of Psychology*, 1963, *119*, 985-986.

Bell, R. G. Who is qualified to treat the alcoholic? Comment on the Krystal-Moore discussion. *Quarterly Journal of Studies on Alcohol*, 1964, *25*, 562-568.

Bennett, A. E., McKeever, L. G., & Turk, R. E. Psychotic reactions during tetraethylthiuram disulfide (antabuse) therapy. *Journal of American Medical Association*, 1951, *145*, 483-484.

Blane, H. T., & Meyers, W. R. Behavioral dependence and length of stay in psychotherapy among alcoholics. *Quarterly Journal of Studies on Alcohol*, 1963, *24*, 503-510.

Blane, H. T., & Meyers, W. R. Social class and establishment of treatment relations by alcoholics. Journal of Clinical Psychology, 1964, 22, 287-290.

Blane, H. T., Overton, W. F., & Chafetz, M. E. Social factors in the diagnosis of alcoholism. I. Characteristics of the patient. Quarterly Journal of Studies on Alcohol, 1963, 24, 640-663.

Block, M. A. A program for the homeless alcoholics. Quarterly Journal of Studies on Alcohol, 1962, 23, 644-649.

Blum, E. M. Psychoanalytic views on alcoholism. Quarterly Journal of Studies on Alcohol, 1966, 27 (2), 259-299.

Blum, R. H. A common sense guide for patients to hospitals and medical care. New York: Macmillan, 1964.

Blum, E. M., & Blum, R. H. Alcoholism. San Francisco: Jossey-Bass, 1967.

Bourne, P. G., Alford, J. A., & Bowcock, J. Z. Treatment of skidrow alcoholics with disulfiram. (Prepublication abstract) Quarterly Journal of Studies on Alcohol, 1965, 26.

Brunner-Orne, M. Ward group sessions with hospitalized alcoholics as motivation for psychotherapy. International Journal of Group Psychotherapy, 1959, 9, 219-224.

Bunzel, R. The role of alcoholism in two Central American cultures. Psychiatry, 1940, 3, 361-387.

Cabrera, F. J. Group psychotherapy and psychodrama for alcoholic patients in a state hospital rehabilitation program. Group Psychotherapy, 1961, 14, 154-159.

Calhoun, J. B. Population density and social pathology. Scientific American, 1962, 206, 139-148.

Caplan, G. An approach to community mental health. New York: Grune & Stratton, 1961.

Chafetz, M. E. Practical and theoretical considerations in the psychotherapy of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1959, *20*, 281-291.

Chafetz, M. E., Blane, H. T., & Hill, M. Social factors in the diagnosis of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1965, *26*, 72-79.

Cherkas, M. S. Synanon foundation--A radical approach to the problem of addiction. *American Journal of Psychiatry*, 1965, *121*, 1065-1068.

Child, I. L., Bacon, M. K., & Barry, H. A. A cross cultural study of drinking. *Quarterly Journal of Studies on Alcohol*, Supplement 3, 1965.

Cisin, I. H., & Cahalan, D. Social research project: National survey of drinking. Unpublished, 1966.

Clinebell, Jr., H. J. *Understanding and counseling the alcoholic*. (Rev. ed.) Nashville, Tenn.: Abingdon Press, 1968.

Committee on Public Health Relations of the New York Academy of Medicine. A survey of facilities for the care and treatment of alcoholism in New York City. *Quarterly Journal of Studies on Alcohol*, 1946, *7*, 405-438.

Conger, J. J. Reinforcement theory and the dynamics of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1956, *17*, 296-305.

Corsini, R. J., & Rosenberg, B. Mechanisms of group psychotherapy: Processes and dynamics. *Journal of Abnormal and Social Psychology*, 1955, *15*, 406-411.

Cumming, J., & Cumming, E. *Ego and milieu: Theory and practice of environmental therapy*. New York: Atherton, 1962.

Davies, D. L. Normal drinking in recovered alcohol addicts. *Quarterly Journal of Studies on Alcohol*, 1962, *23*, 94-104.

Demone, Jr., H. W. Experiments in referral to alcoholism clinics. *Quarterly Journal of Studies on Alcohol*, 1963, *24*, 495-502.

Dent, J. Y. Discussion on the management of the alcoholic in general practice. *Proceedings of the Royal Society of Medicine*, 1954, *47*, 331-333.

Diagnostic and statistical manual of mental disorders. (2nd ed.) The American Psychiatric Association, 1968.

Dollard, J., & Miller, N. *Personality and psychotherapy*. New York: McGraw-Hill, 1950.

Erikson, E. H. The problem of ego identity. *Quarterly Journal of Studies on Alcohol*, 1956, *4*, 56-121.

Ezriel, H. A psychoanalytic approach to group treatment. *British Journal of Medical Psychology*, 1950, *23*, 59-74.

Fejos, P. Man, magic, and medicine. In I. Galdston (Ed.), *Medicine and anthropology*. New York: International University Press, 1959.

Feldmann, H. The ambulatory treatment of alcoholic addicts: A study of 250 cases. *British Journal of Addiction*, 1959, *55*, 121-127.

Foley, A. R., & Sanders, D. S. Theoretical considerations for the development of the community mental health center concept. *American Journal of Psychiatry*, 1966, *122*, 985-990.

Fox, R. Children in the alcoholic family. In W. C. Bier (Ed.), *Problems in addiction: Alcoholism and narcotics*. New York: Fordham University Press, 1962.

Fox, R. Psychodrama with alcoholics. Article prepared for the *Encyclopedia on problems of alcoholism*. Stanford: Institute for the Study of Human Problems, 1962.

Fox, R. *Alcoholism-behavioral research therapeutic approaches*. New York: Springer Publishing Co., 1967.

Franks, C. M. Alcohol, alcoholism and conditioning. In H. J. Eysenck (Ed.), *Behavior therapy and the neuroses: Readings in modern methods of treatment derived from learning theory. Part IV: Aversion therapy*. New York: Pergamon, 1960.

Franks, C. M. Behavior therapy, the principles of conditioning and the treatment of the alcoholic. *Quarterly Journal of Studies on Alcohol*, 1963, *24*, 511-529.

Glatt, M. M. Normal drinking in recovered alcohol addicts: Comment on the article by D. L. Davies. *Quarterly Journal of Studies on Alcohol*, 1965, *26*, 116-117.

Grunwald, H. Group counseling in a case work agency. *International Journal of Group Psychotherapy*. 1954, *4*, 183-192.

Haggard, H. W. The physician and the alcoholic. *Quarterly Journal of Studies on Alcohol*, 1945, *6*, 213-221.

Hayman, M. The general practitioner and the alcoholic. *Mind: Psychiatry in General Practice*, 1963, *1*, 198-222.

Hsu, F. L. K. Electroconditioning therapy of alcoholics. *Quarterly Journal of Studies on Alcohol*, 1965, *26*, 449-459.

Jackson, J. K. The adjustment of the family to alcoholism. *Marriage and Family Living*, 1956, *18*, 361-369.

Jackson, J. K. Alcoholism and the family. In D. J. Pittman & C. R. Snyder (Eds.), *Society, culture and drinking patterns*. New York: Wiley, 1962.

Jacobsen, E., & Martensen-Larsen, O. Treatment of alcoholism with tetraethylthiruam disulfide (antabuse). *Journal of American Medical Association*, 1949, *139*, 918-922.

Jahoda, M. Current concepts of positive mental health. *Joint commission on mental illness and health*. New York: Basic Books, 1958.

Jellinek, E. M. *The disease concept of alcoholism*. New Haven: Hillhouse, 1960.

Jones, M. *The therapeutic community: A new treatment method in psychiatry*. New York: Basic Books, 1953.

Katz, L. The Salvation Army men's social service center: I. Program. *Quarterly Journal of Studies on Alcohol*, 1964, *25*, 324-332. The Salvation Army men's social service center: II. Results. *Quarterly Journal of Studies on Alcohol*, 1966, *27*, 636-647.

Keller, M. The definition of alcoholism and the estimation of its prevalence. In D. J. Pittman & C. R. Snyder (Eds.), *Society, culture and drinking patterns*. New York: Wiley, 1962.

Keller, M. Documentation of the alcohol literature: A scheme for an interdisciplinary field of study. *Quarterly Journal of Studies on Alcohol*, 1964, *25*, 725-741.

Kiev, A. (Ed.) *Magic, faith, and healing*. New York: Free Press, 1964.

Kogan, K. L., & Jackson, J. K. Some concomitants of personal difficulties in wives of alcoholics and nonalcoholics. *Quarterly Journal of Studies on Alcohol*, 1965, *26*, 595-604.

Krystal, H., & Moore, A. Who is qualified to treat the alcoholic? A discussion. *Quarterly Journal of Studies on Alcohol*, 1963, *24*, 705-720.

Leighton, A. H., Clausen, J. A., & Wilson, R. N. Introduction: Some key issues in social psychiatry; Orientation. In A. H. Leighton, J. A. Clausen, & R. N. Wilson (Eds.), *Explorations in social psychiatry*. New York: Basic Books, 1957.

Lemere, F. Psychological factors in the conditioned reflex treatment of alcoholism. In E. Podolsky (Ed.), Management of addiction. New York: Philosophical Library, 1955.

Lemere, F., O'Hollaren, P., & Maxwell, A. Motivation in the treatment of alcoholism. Quarterly Journal of Studies on Alcohol, 1958, 19, 428-431.

Lemere, F., & Voegtlin, W. L. An evaluation of the aversion treatment of alcoholism. In E. Podolsky (Ed.), Management of addiction. New York: Philosophical Library, 1955.

Lewis, L., & Coser, R. The dangers of hospitalization. In R. H. Blum (Ed.), Hospitals and patient dissatisfaction. San Francisco: California Medical Association, 1958.

Lewis, M. L. The initial contact with wives of alcoholics. Social Casework, 1954, 35, 8-14.

Lindemann, E. The meaning of crisis in individual and family living. Teachers' College Record, 1956, 57, 310.

Lindemann, E., Chafetz, M. E., & Blane, H. T. Alcohol-crisis treatment approach and establishment of treatment relations with alcoholics. Psychological Reports, 1963, 12, 862.

Lindemann, E., & Clarke, L. D. Modification in ego structure and personality reactions under the influence of the effects of drugs. American Journal of Psychiatry, 1952, 108, 561-567.

Lolli, G. Alcoholism, 1941-1951: A survey of activities in research, education and therapy. V. The treatment of alcohol addiction. Quarterly Journal of Studies on Alcohol, 1952, 13, 461-471.

Lolli, G. On therapeutic success in alcoholism. Quarterly Journal of Studies on Alcohol, 1953, 14, 238-246.

Lolli, G. On therapeutic success in alcoholism. In E. Podolsky (Ed.), Management of addiction. New York: Phiolosophical Library, 1955.

Machover, S., Puzzo, F. S., & Plumeau, F. An objective study of homosexuality in alcoholism. Quarterly Journal of Studies on Alcohol, 1959, 29 (3), 528-542.

Maddox, G. L. Teen-age drinking in the United States. In D. J. Pittman & C. R. Snyder (Eds.), Society, culture and drinking patterns. New York: Wiley, 1962.

Manual on alcoholism. American Medical Association, 1967.

Margolis, M., Krystal, H., & Siegel, S. Psychotherapy with alcoholic offenders. Quarterly Journal of Studies on Alcohol, 1964, 25, 85-99.

Martensen-Larsen, O. Psychotic phenomena provoked by tetraethylthiuram disulfide. Quarterly Journal of Studies on Alcohol, 1951, 12, 208-216.

Martensen-Larsen, O. Group psychotherapy with alcoholics in private practice. International Journal of Group Psychotherapy, 1956, 6, 28-37.

Maxwell, M. Alcoholics anonymous: An interpretation. In D. J. Pittman & C. R. Snyder (Eds.), Society, culture and drinking patterns. New York: Wiley, 1962.

McCord, W., & McCord, J. A longitudinal study of the personality of alcoholics. In D. J. Pittman & C. R. Snyder (Eds.), Society, culture and drinking patterns. New York: Wiley, 1962.

Mead, J. H. Mind, self and society. Chicago: University of Chicago Press, 1934.

Menninger, W. C. The treatment of chronic alcohol addiction. Bulletin of the Menninger Clinic, 1938, 2, 101-112.

Miles, R. B., & Hetrick, E. S. Treating the unmotivated alcoholic: A coordinated program in a municipal court. Crime and Delinquency, 1963, 9, 46-59.

Miller, N. E. Learnable drives and rewards. In S. S. Stevens (Ed.), *Handbook of experimental psychology*. New York: Wiley, 1951.

Mindlin, D. F. The characteristics of alcoholics related to prediction of therapeutic outcome. *Quarterly Journal of Studies on Alcohol*, 1959, *20*, 604-619.

Mindlin, D. F. Attitudes toward alcoholism and towards self: Differences between three alcoholic groups. *Quarterly Journal of Studies on Alcohol*, 1964, *25*, 136-141.

Moore, R. A. Reaction formation as a counter-transference phenomenon in the treatment of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1961, *22*, 481-486.

Moore, R. A., & Murphy, T. C. Denial of alcoholism as an obstacle to recovery. *Quarterly Journal of Studies on Alcohol*, 1961, *22*, 597-609.

Moore, R. A., & Ramseur, F. Effects of psychotherapy in an openward hospital on patients with alcoholism. *Quarterly Journal of Studies on Alcohol*, 1960, *21*, 233-253.

Morris, J. M. *The uses of epidemiology*. London: Livingstone, 1957.

Myersen, D. J., Mackay, J., Wallens, A., & Neiberg, N. A report of a rehabilitation program for alcoholic women prisoners. *Quarterly Journal of Studies on Alcohol*, Supplement 1, 151-157.

Palola, E. G., Dorpat, T. L., & Larson, W. R. Alcoholism and suicidal behavior. In D. J. Pittman & C. R. Snyder (Eds.), *Society, culture and drinking patterns*. New York: Wiley, 1962.

Parloff, M. B. Therapist patient relationships and outcome of psychotherapy. *Journal of Consulting Psychology*, 1961, *25*, 29-38.

Pattison, E. M., Courlas, P. G., Patti, R., Mann, B., & Mullen, D. Diagnostic-therapeutic intake groups for wives of alcoholics. *Quarterly Journal of Studies on Alcohol*, 1965, *26*, 605-616.

Paul, J. R. *Clinical epidemiology*. Chicago: University of Chicago Press, 1958.

Pearlin, L. I. Treatment values and enthusiasm for drugs in a mental hospital. *Psychiatry*, 1962, *25*, 170-179.

Pfeffer, A. Z. *Alcoholism*. New York: Grune-Stratton, 1958.

Pittman, D. J. The role of sociology in the planning and operation of alcoholism treatment programs. *British Journal of Addiction*, 1963, *59*, 35-39.

Pittman, D. J. (Ed.) *Alcoholism*. New York Harper & Row, 1967.

Pittman, D. J., & Gordon, C. W. *Revolving door: A study of the chronic police case inebriate*. Monographs of the Yale Center of Alcohol Studies No. 2. New Haven & Glencoe: Free Press, 1958.

Pittman, D. J., & Snyder, C. R. (Eds.), *Society, culture and drinking patterns*. New York: Wiley, 1962.

Pittman, D. J., & Sterne, M. Concept of motivation: Sources of institutional and professional blockage in the treatment of alcoholics. *Quarterly Journal of Studies on Alcohol*, 1965, *26*, 41-57.

Pixley, J. M., & Stiefel, J. R. Group therapy designed to meet the needs of the alcoholic's wife. *Quarterly Journal of Studies on Alcohol*, 1963, *24*, 304-314.

Powdermaker, F. The relation between the alcoholic and the physician. *Quarterly Journal of Studies on Alcohol*, 1944, *5*, 245.

Price, G. Social casework in alcoholism. *Quarterly Journal of Studies on Alcohol*, 1958, *19*, 155-163.

Rees, T. P. Back to moral treatment and community care. *Journal of Medical Science*, 1957, *103*, 303-313.

Riley, Jr., J. W., & Marden, C. F. The medical profession and the problem of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1946, *7*, 240-270.

Rioch, M. J. Changing concepts in the training of therapists. *Journal of Consulting Psychology*, 1966, *30*, 290-291.

Roe, A. Alcohol and creative work. I. Painters. *Quarterly Journal of Studies on Alcohol*, 1946, *6*, 415-567.

Rosenbaum, M. Some comments on the use of untrained therapists. *Journal of Consulting Psychology*, 1966, *30*, 292-294.

Sapir, J. V. Relationship factors in the treatment of the alcoholic. *Social Casework*, 1953, *34*, 297-303.

Sapolsky, A. Relationships between patient, doctor compatibility, mutual perception, and outcome of treatment. *Journal of Abnormal Psychology*, 1965, *70*, 70-76.

Saunders, L. *Cultural differences and medical care*. New York: Russell Sage Foundation, 1954.

Schaffer, L., & Myers, J. K. Psychotherapy and social stratification: An empirical study of practice in a psychiatric outpatient clinic. *Psychiatry*, 1954, *17*, 83-93.

Schremly, J., & Solomon, P. Drug abuse and addiction reporting in a general hospital. *Journal of the American Medical Association*, 1964, *189* (6), 512-514.

Selzer, M. L. Hostility as a barrier to therapy in alcoholism. *Psychiatric Quarterly*, 1957, *31*, 301-305.

Selzer, M. L., & Holloway, W. H. A follow-up of alcoholics committed to a state hospital. Quarterly Journal of Studies on Alcohol, 1957, 18, 98-120.

Solomon, R. L. Punishment. Psychologist, 1964, 19, 239-253.

Sterne, M. W., & Pittman, D. J. The concept of motivation: A source of institutional and professional blockage in the treatment of alcoholics. Quarterly Journal of Studies on Alcohol, 1965, 26, 41-57.

Stevenson, I. Discussion of J. Wolpe: The conditioning therapies and psychoanalysis. In J. Wolpe, A. Salters, & L. J. Reyna (Eds.), The conditioning therapies: The challenge in psychotherapy. New York: Holt, Rinehart, & Winston, 1964.

Straus, R. Medical practice and the alcohol. In E. Jaco (Ed.), Patients, physicians and illness. Glencoe, Ill.: Free Press, 1948.

Straus, R. Community surveys, their aims and techniques. Quarterly Journal of Studies on Alcohol, 1952, 13, 254-270.

Straus, R., & Bacon, S. D. The problems of drinking in college. In D. J. Pittman & C. R. Snyder (Eds.), Society, culture and drinking patterns. New York: Wiley, 1962.

Straus, R., & McCarthy, R. G. Nonaddictive pathological drinking patterns of homeless men. Quarterly Journal of Studies on Alcohol, 1951, 12, 601-611.

The twelve steps and twelve traditions. New York: Alcoholics Anonymous, 1953.

United States Government Printing Office. Alcoholism and vocational rehabilitation. Washington, D. C.: USGPO, 1966.

United States Government Printing Office. Alcohol and alcoholism. Washington, D. C.: USGPO, 1967.

United States Government Printing Office. Task force report: Drunkenness. Washington, D. C.: USGPO, 1967.

Van Der Veen, F. Effects of the therapist and the patient on each other's therapeutic behavior. Journal of Consulting Psychology, 1965, 29, 19-26.

Wallerstein, R. S. et al. Hospital treatment of alcoholism. New York: Basic Books, 1957.

Warkov, S., Bacon, S. D., & Hawkins, A. C. Social correlates of industrial drinking. Quarterly Journal of Studies on Alcohol, 1965, 26 (1), 58-71.

Weber, M. The sociology of religion. Trans. Fischoff. Boston: Beacon, 1963.

Wedel, H. L. Involving alcoholics in treatment. Quarterly Journal of Studies on Alcohol, 1965, 26, 468-479.

Wenneis, A. C. Responding to the emotional needs of the alcoholic. Social Casework, 1957, 38, 189-193.

Witkin, H., Karp, S., & Goodenough, D. Dependence in alcoholics. Quarterly Journal of Studies on Alcohol, 1959, 20, 493-504.

Wolf, H. G. Stress and disease. Springfield, Ill.: Thomas, 1953.

Wolf, I. et al. Social factors in the diagnosis of alcoholism. II. Attitudes of physicians. Quarterly Journal of Studies on Alcohol, 1965, 26, 71-79.

Wolpe, J. Psychotherapy by reciprocal inhibition. Stanford: Stanford University Press, 1958.

Wolpe, J., Salter, A., & Reyna, L. J. (Eds.) The conditioning therapies: The challenge in psychotherapy. New York: Holt, Rinehart & Winston, 1964.

Yolles, S. F. Community mental health: Issues and policies. American Journal of Psychiatry, 1966, 122, 779-785.

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